



ENT FOR PRIMARY CARE PHYSICIANS

COLLEGE OF OTORHINOLARYNGOLOGY AND HEAD AND NECK SURGEONS

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2023

OBJECTIVES

- To familiarise with with common ENT problems faced by primary care doctors
- Early identification of conditions
- Know what initial treatment can be offered
- Know when to refer to ENT
- Avoid missing a cancer patient

WHAT INSTRUMENTS DO WE NEED

- Otoscope
- Torch
- Tongue Depressor
- Thudicum speculum
- Jobson Horbe Probe

- Please note not all equipment may be available in a periferal setting and if proper visualisation is not possible- please seek ENT opinion.

CONTENTS

- Ear Conditions
- Ear Discharge
- Wax in ear
- FB in ear
- Hearing loss
- Traumatic ear drum perforation
- Ear ache
- Otoscopic findings

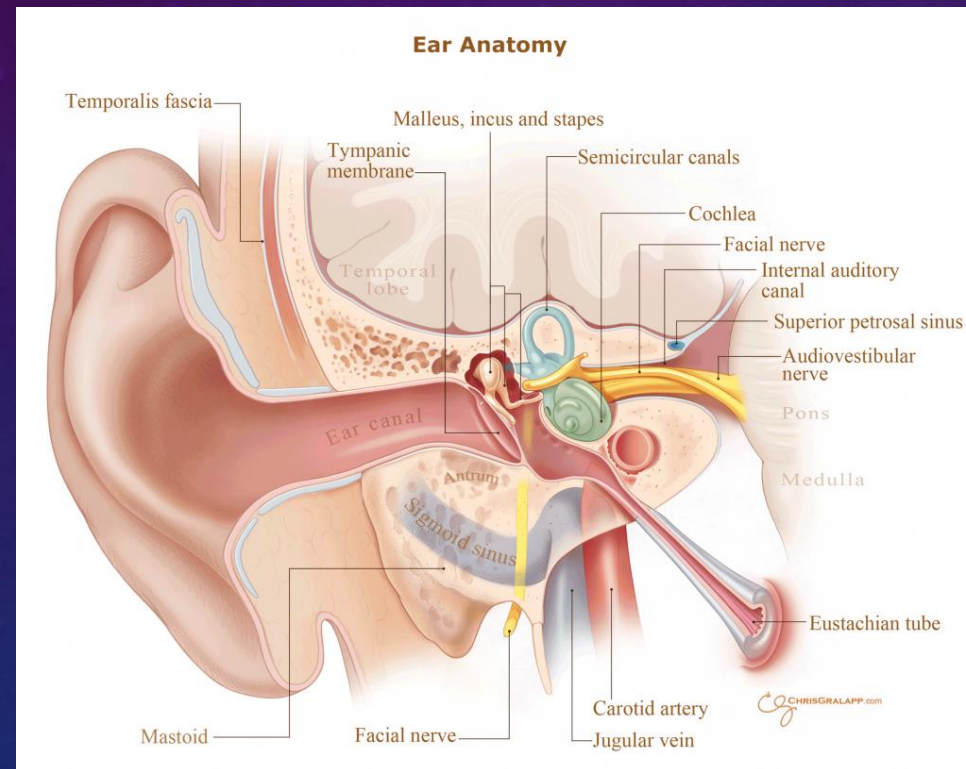
- Nasal pathology

- Foreign body in nose
- Sinusitis
- Epistaxis

- Throat and head and neck

- Tonsillitis
- Peri tonsillar abscess
- Neck infections
- Foreign body injestion
- Trauma

ANATOMY



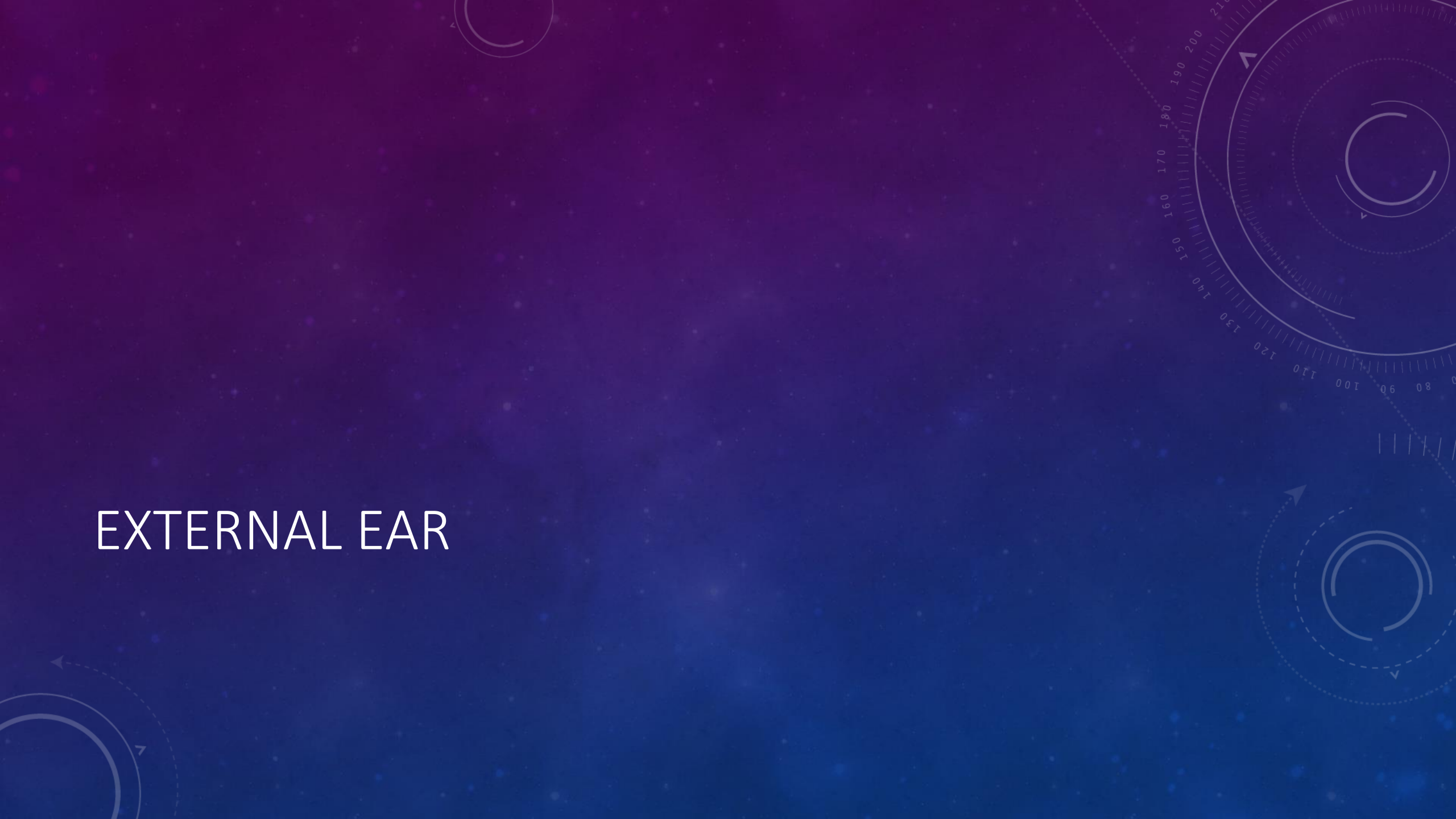
HEARING LOSS

- Often presents with gradual hearing loss or sudden hearing loss
- May be associated with ear discharge, ear fullness, tinnitus, vertigo.
- Need to distinguish if its sudden onset sensorineural hearing loss as there is a very narrow therapeutic window.
- Examination of ear is important to rule out wax impaction , perforation or ear infection – needs appropriate treatment

SUDDEN ONSET HEARING LOSS

- Examine ears.
- If no obvious pathology is seen please refer to Ent for urgent hearing assesment as treatment needs to be commenced within 72 hours for better prognosis.
- Any hearing loss occurred within 2-4 weeks period should be referred without delay

EXTERNAL EAR



CONGENITAL DEFORMITIES

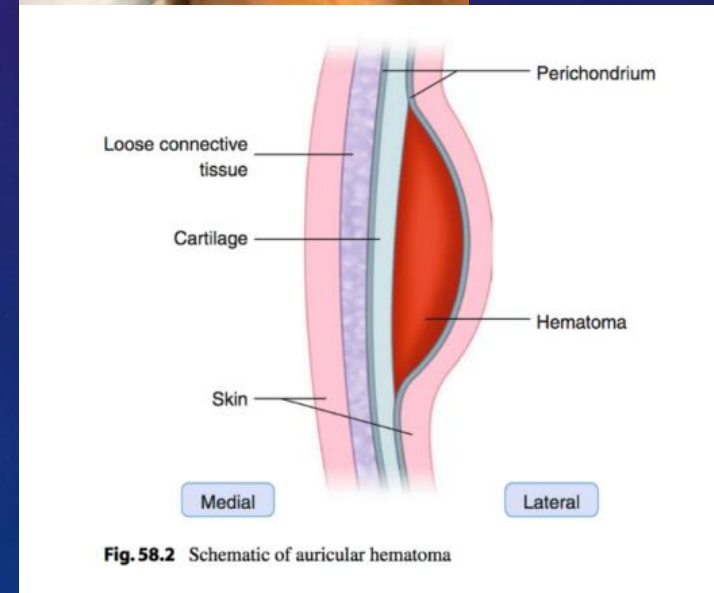


- Deformities:
 - Tags
 - Pre auricular pits and sinuses
 - Macrotia
 - Bat ear
 - Lop ear
 - Microtia - anotia
 - Atresia of EAC

- Needs referral to ENT

AURICULAR HAEMATOMA

- Caused by blunt injury to the auricle
- Common in contact sports – boxing/ wrestling etc.
- Injury to a perichondrial blood vessel results in blood accumulation in the subperichondrial space, elevating the perichondrium off of the cartilage causing necrosis



AURICULAR HAEMATOMA TREATMENT

- Evacuation of the haematoma and application of a pressure dressing to prevent re-accumulation
- Wide incision with a scalpel is preferred.
- Incisions should be placed parallel to the helix in the scapha.
- After drainage and removal of clot and fibrocartilage, bolster dressings should be applied with through and through sutures for 2 weeks.
- Preferably done in specialized Ent unit



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EAR WAX

IMPACTED WAX

- Excess collection of thick ear wax is known as impacted wax
- Symptoms
 - Diminished hearing – often of sudden onset after “cleaning” the ears
 - Discomfort – seldom complain of pain unless the wax is pressing on the drum
 - Tinnitus occasionally



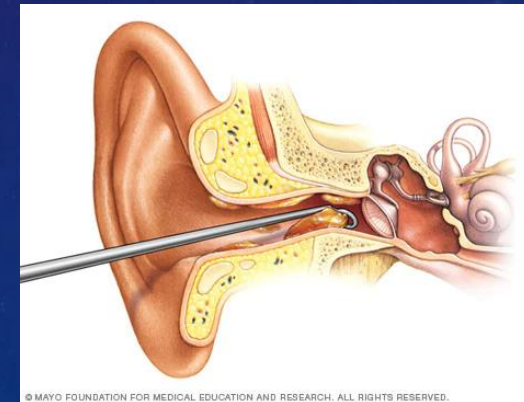
IMPORTANT TO REMEMBER

- Wax has an important role in protecting the ear canal
- The ear canal is a self-cleaning system
- do not to use cotton buds as wax is more likely to be pushed back against the eardrum and become impacted.
- Ear wax only needs to be removed if it causes symptoms or if a proper view of the eardrum is needed.



TREATMENT

- use of a ceruminolytic ear drop for 4 to 5 days
 - Sodium bicarbonate solution
 - Olive oil
- Syringing (only by trained staff)
- Removal with wax hook under direct vision



EAR IRRIGATION

- Should only be done by a trained medical
- DO NOT ATTEMPT if you don't have the expertise
- The lowest pressure possible should be used.
- It is best avoided if
 - the eardrum is known or suspected to be perforated
 - there is a history of mastoid surgery or chronic middle ear disease
 - If patient has unilateral deafness
 - A history of recurrent otitis externa or tinnitus



The background features a dark blue gradient with a subtle pattern of white stars. On the left side, there are several technical diagrams in a lighter blue color. These include a large circular scale with numerical markings from 140 to 260, and several smaller circular diagrams with arrows indicating clockwise or counter-clockwise rotation. The text 'FOREIGN BODIES OF EAR' is centered in the lower half of the image in a white, sans-serif font.

FOREIGN BODIES OF EAR

- most commonly in the ear are cotton wool, insects, beads, paper, small toys and erasers.
- Most commonly seen in children
- Prior to embarking upon removal, consider three aspects of the situation:
 1. the nature of the foreign body;
 2. the precise location of the foreign body;
 3. the patient.



PRACTICAL TIPS

- **Always consider transferring the patient to an ENT Department**
- Risk of trauma to ear is high in blind removal
- Initial medication can be instilled to kill live insect prior to referral.
- Children often give us only one chance to remove....

TYPE OF FOREIGN BODY METHOD OF REMOVAL

- Living insects
- Irregular/graspable objects
- Organic/vegetable
- Button batteries
- Round, hard, smooth, non-graspable under anaesthetic

First kill with oil

Remove with crocodile forceps

Do not syringe

Do not syringe

Syringe/remove with wax hook/removal



TRAUMATIC PERFORATION

- Diagnosis
 - History of trauma
 - Ragged edges of the perforation
 - Blood stained
- Treatment
 - **NO EAR DROPS**
 - Keep ear dry
 - Antibiotics not needed unless infected
 - Refer to ENT for hearing assesment and medicolegal procedings
 - Need FU in 1 month



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OTITIS EXTERNA

DEFINITION

- Otitis externa is a generalized condition of the skin of the external auditory canal that is characterized by
 - General oedema and erythema
 - itchy discomfort
 - ear discharge.

ACUTE LOCALISED OTITIS EXTERNA (FURUNCLE)

- begin as folliculitis /small abscess/furuncle
- *Staphylococcus aureus*
- Lateral cartilaginous (outer 1/3rd) portion of EAC
- Symptoms – severe pain/discharge/hearing loss/aural fullness
- O/E – tragal tenderness/oedematous EAC/enlarged, tender preauricular LN



TREATMENT

- Early cases without abscess formation
 - Systemic antibiotics
 - Topical antibiotics+corticosteroids
 - Analgesics/local hot fomentation/ear pack
- If abscess has formed
 - Incision & Drainage
 - Topical antibiotic ointment with/without oral antibiotics
- Recurrent furunculosis
 - R/o diabetes, staphylococcal skin infection, nasal vestibule harbouring staphylococci

ACUTE DIFFUSE OTITIS EXTERNA / SWIMMER'S EAR

- Commonest form of otitis externa
- Usual pathogens – *Pseudomonas aeruginosa*, *Staphylococcus aureus*, *Proteus mirabilis*

• Symptoms:

• O/E – ten

loss

edematous skin/ clear or purulent exudates



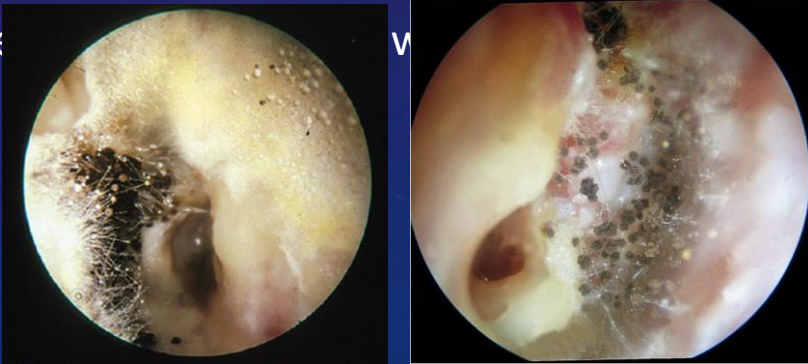
- Treatment:
 - Ear toilet
 - Medicated wicks with Antibiotics / steroids
 - Antibiotics –Topical with/without corticosteroids / Broad spectrum systemic antibiotics
 - Analgesics
- Avoid water entry/avoid using cotton buds/avoid digital manipulation of ear canal

FUNGAL OTITIS EXTERNA (OTOMYCOSIS)

- Fungal infection of EAC
- *Aspergillus niger* – black headed filamented growth
- *Aspergillus fumigatus* – brown
- *Candida albicans* – white/creamy deposits
- Secondary fungal infection may be seen in pts using topical antibiotics for otitis externa/ middle ear suppuration

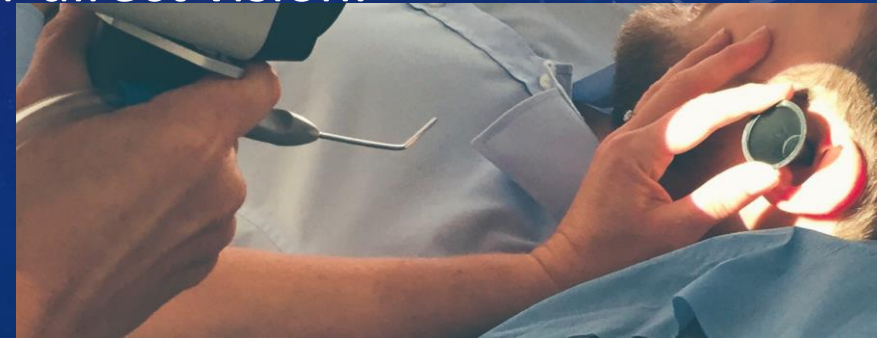
• Symptoms: pruritis/ pain or discomfort in ear/ watery discharge with musty odour/ ear block

• O/E: e... v... e fungal mass – 'wet piece of filter paper'



TREATMENT

- Ear toilet
- Topical Antifungal agents – Beclomethasone/clotrimazole topical drops/ointments
 - Needs a prolonged course of treatment to avoid recurrences from remaning spores
- Ear must be kept dry
- Secondary bacterial infections – antibiotic + steroid prepration
- Refer to ENT for ear toileting – needs to be cleared under direct vision.



The background features a dark blue gradient with a subtle pattern of white stars and technical diagrams. On the left side, there are several circular diagrams with concentric lines and arrows, resembling a gauge or a scale. One prominent diagram has a scale from 140 to 260 in increments of 10. Other diagrams show partial circles with arrows indicating direction. The overall aesthetic is clean, modern, and technical.

ACUTE OTITIS MEDIA

- Acute inflammation in middle ear
- < 3 weeks
- Often associated with a viral upper respiratory infection
- Most common reason for medical therapy for children younger than 5 years

- Recurrent otitis media:
 - At least 4 episodes/ year
 - At least 3 episodes/ 6 months (with adequate therapy) Acute otitis media

CAUSES

- Triggers:

- Allergies

- Upper respiratory tract infections

- GER (especially children)

- Adenoid hypertrophy

- Dental

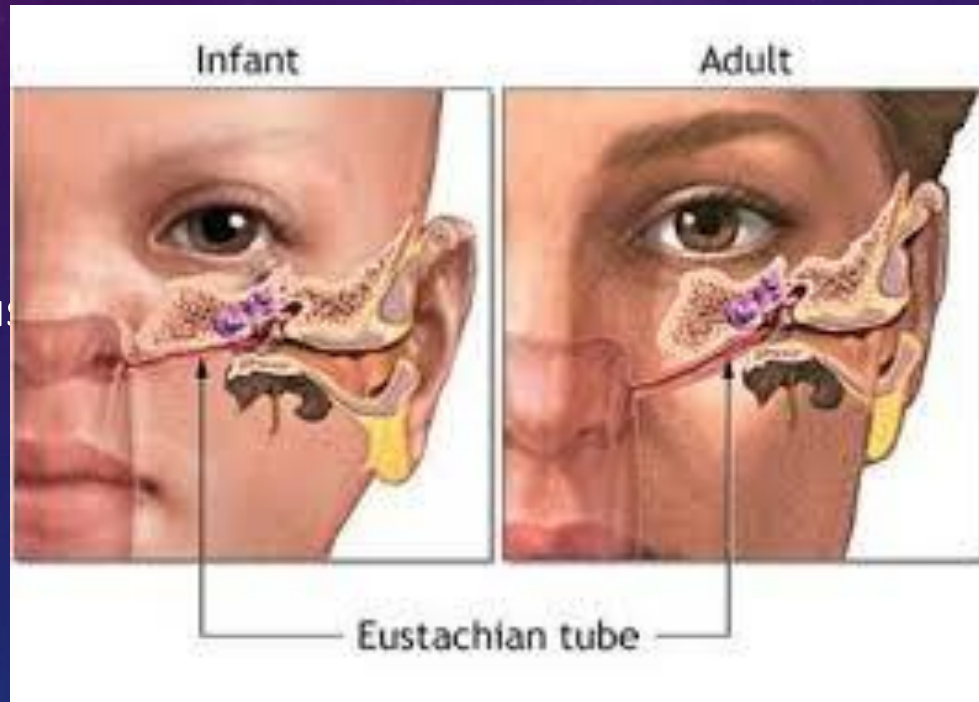
- Other

- Infections

- Viral (30-70%) - RSV / Rhinovirus / Coronavirus / Influenza, parainfluenza

- Bacterial (55%) - Streptococcus pneumoniae (44%) / Haemophilus influenzae (41%) / Moraxella catarrhalis (14%) / Gram negative enteric bacteria / S. Aureus

- <7 years of age - Eus



d poorly functioning

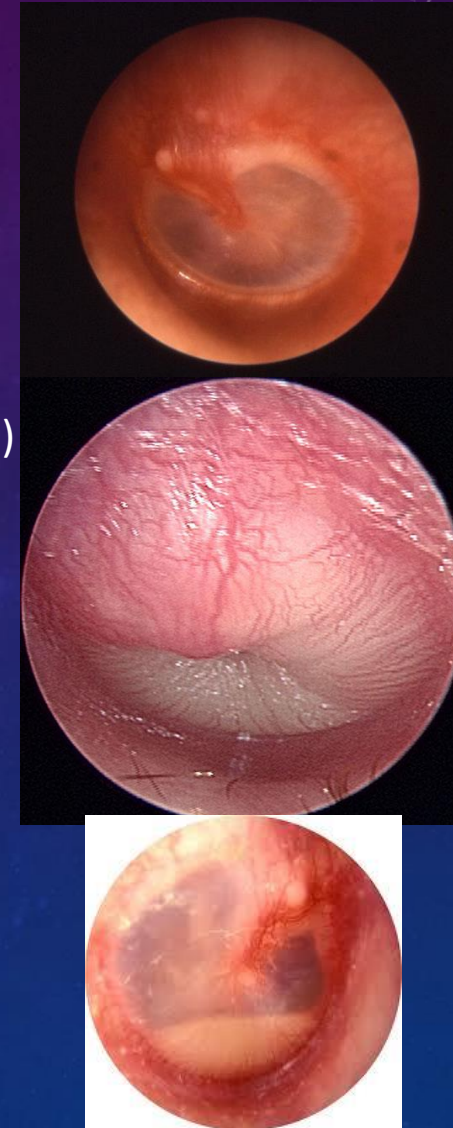
SIGNS AND SYMPTOMS

- Otalgia
- Fever
- Hearing loss (speech delay for children)
- Headache
- Nausea
- Cough
- Rhinitis
- Conjunctivitis



SIGNS AND SYMPTOMS

- Pneumatic otoscopy/otoscopy
 - Red or opaque eardrum
 - Retracted eardrum
 - Immobile or hypo-mobile eardrum
 - Presence of fluid behind eardrum (purulent, serous, mucoid)
 - Retraction pockets
 - Bullous Myringitis
- Physical Examination
 - Otorrhoea (in case of tympanostomy tube, perforation)
 - Mastoid tenderness
 - Anteriorly rotated pinna
 - Inspection or pharynx and nasal cavity



Otitis Media (Acute) By Richard T. Miyamoto , MD, MS, Indiana University School of Medicine

TREATMENT

- Antibacterial therapy for:
 - Children of age <6months ☐ 6 months to 2 years with severe illness
 - Recurrent or bilateral AOM
 - Immunocompromised patients
 - Patients with a perforated tympanic membrane ?
- Pain management (Ibuprofen, Diclofenac, Paracetamol)
- Decongestants and/or antihistamines, nasal steroids

- After 24-48h (48-72h) If no improvements
 - No antibiotics > antibiotics
 - Antibiotics > change to a different antibiotics
- Recurrent AOM treatment – Tympanostomy / Myringotomy

COMPLICATIONS

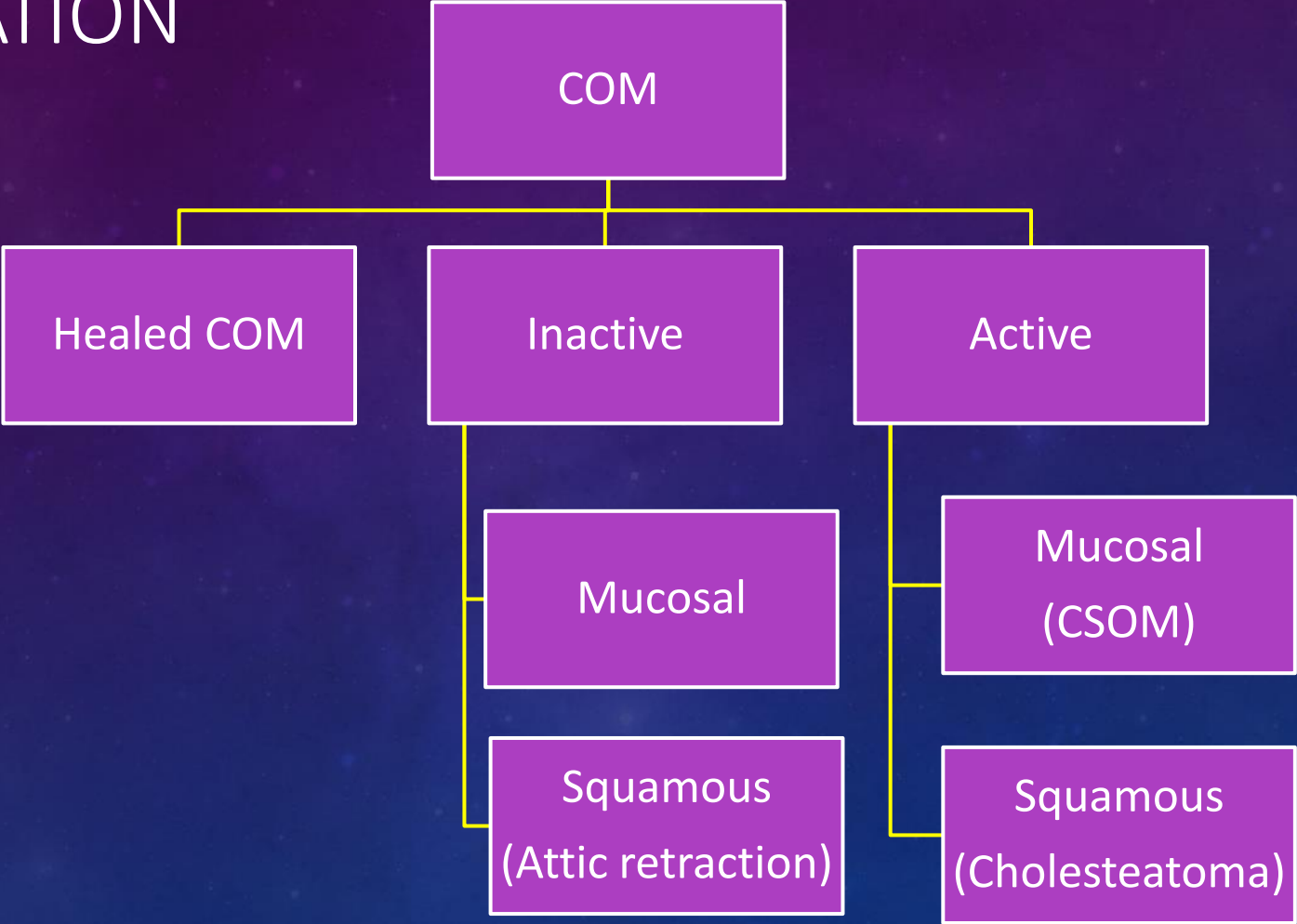
- Similar to Chronic Otitis media but could be more aggressive
- Acute mastoiditis
- Abscess formation
- Facial paralysis
- Otitis media with effusion
- Persistent AOM
- Recurrent AOM
- Hearing loss
- Perforation of eardrum
- Lateral sinus thrombosis / Otitic hydrocephalus /Septic shock/Meningitis /Encephalitis /Extradural abscess /Labyrinthitis are rare
- REFER TO ENT DEPARTMENT

The background features a dark blue gradient with a subtle pattern of white dots. On the left side, there are several overlapping circular elements. A prominent one is a large arc with a scale from 140 to 260 in increments of 10. Other circles include dashed lines, solid lines, and arrows, suggesting a technical or scientific theme.

CHRONIC OTITIS MEDIA

- Permanent abnormality of the pars tensa or flaccida
- Most likely a result of
 - earlier acute otitis media
 - negative middle ear pressure
 - otitis media with effusion

CLASSIFICATION

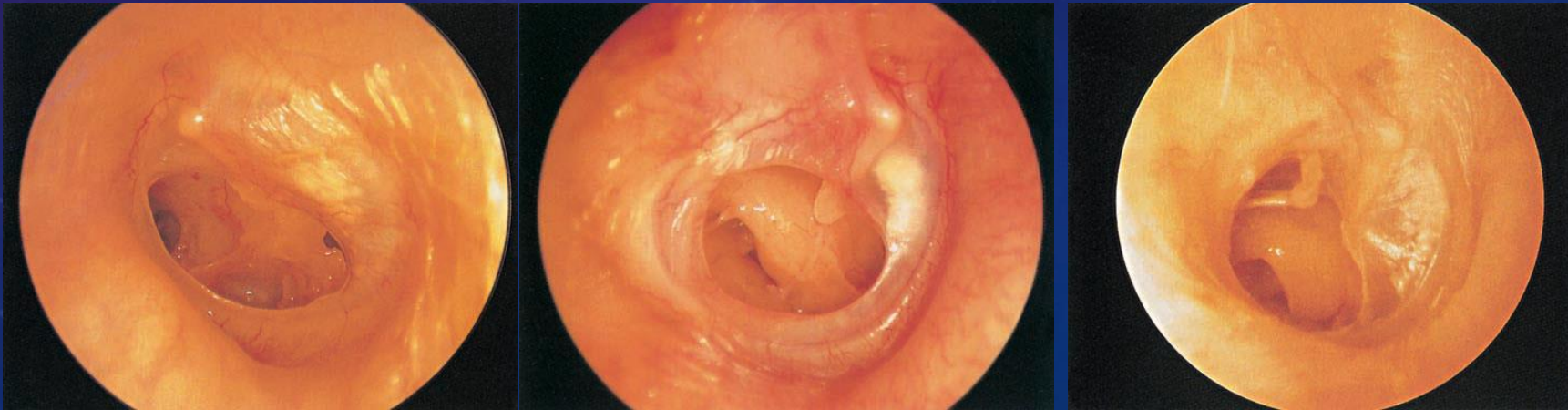


INACTIVE CHRONIC MUCOSAL OTITIS MEDIA

The background is a dark blue gradient with a fine, starry texture. On the right side, there are several technical diagrams. A large circular scale with numerical markings from 80 to 210 is visible, along with various concentric circles, dashed lines, and arrows, suggesting a complex technical or scientific theme.

INACTIVE CHRONIC MUCOSAL OTITIS MEDIA

- Permanent perforation of the pars tensa
- The middle ear and mastoid mucosa is **not** inflamed.
- Perforation may be completely surrounded by a remnant of the pars tensa
- or a part of the perforation may extend to the fibrous annulus



INACTIVE CHRONIC MUCOSAL OTITIS MEDIA

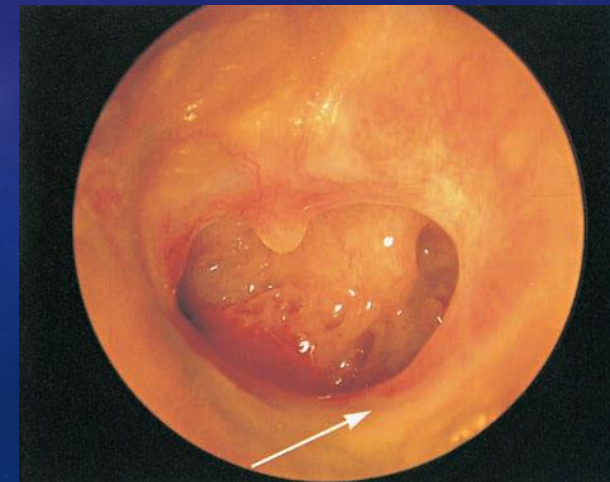
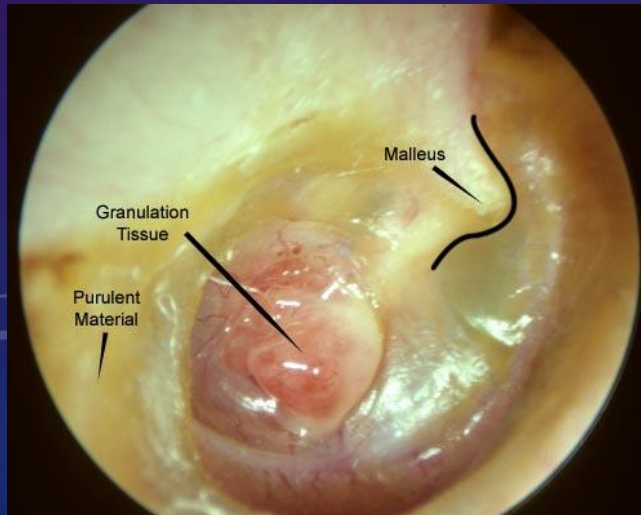
- Often presents with a hearing impairment
- May be an incidental finding in older patients with a mixed impairment
- Needs referral to Ent department for hearing assessment and to consider management options
- Pure-tone audiometry - assesses the magnitude of the conductive hearing impairment
- Treatment
 - Surgery – Tympanoplasty/ Myringoplasty
 - Hearing aid devices
 - No treatment – dry ear precautions

ACTIVE CHRONIC MUCOSAL OTITIS MEDIA

The background is a dark blue gradient with a subtle pattern of small white dots. On the right side, there are several circular graphic elements. One prominent feature is a large circular scale with numerical markings from 80 to 210, arranged in a clockwise direction. There are also several concentric circles, some solid and some dashed, with arrows indicating a clockwise direction of rotation. The overall aesthetic is technical and scientific.

ACTIVE CHRONIC MUCOSAL OTITIS MEDIA

- Chronic inflammation within the mucosa of the middle ear and mastoid
 - usually perforation of pars tensa
 - varying degrees of oedema, submucosal fibrosis, hypervascularity and infiltration with lymphocytes, plasma cells and histiocytes
 - formation of granulation tissue.
 - production of mucopurulent discharge.
 - form 'aural polyps' that can protrude through defects of the tympanic membrane.
 - often associated with resorption of parts or all of the ossicular chain and bone erosion



ACTIVE CHRONIC MUCOSAL OTITIS MEDIA MANAGEMENT

- Medical
 - Aural toilet – swab for culture, dry mopping , suction clearance under microscope
 - **Antibiotic ear drops /steroids antiseptics – important 1st line treatment**
 - Systemic antibiotics if acute exacerbation of the disease
- Surgical
 - Removal of septic foci – tonsillectomy , adenoidectomy , sinus clearance
 - Myringoplasty / Tympanoplasty when converted to inactive stage
 - If associated mastoiditis – cortical mastoidectomy
- Refer to ENT if initial treatment not responding

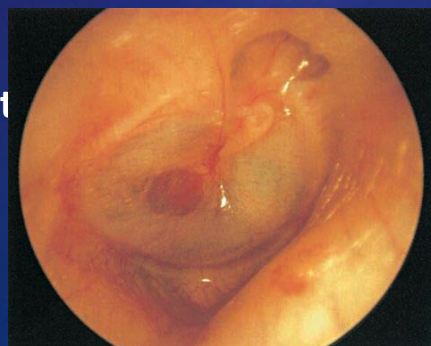
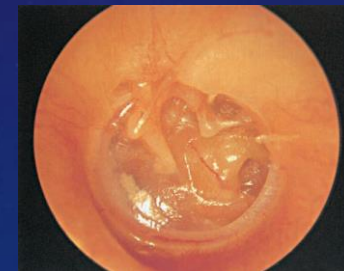


INACTIVE CHRONIC SQUAMOUS OTITIS MEDIA

The background is a dark blue gradient with a field of small white stars. On the right side, there are several technical diagrams. One is a large circular scale with markings from 80 to 210 and a central circle with an arrow. Another is a smaller circular diagram with concentric circles and an arrow. A third is a dashed circular arrow pointing left. There are also some faint circular outlines in the top left and bottom left corners.

INACTIVE CHRONIC SQUAMOUS OTITIS MEDIA

- Negative static middle ear pressure can result in retraction (atelectasis) of the tympanic membrane.
- A 'retraction pocket' - invagination into the middle ear space of a part of the ear drum
- occur in the pars tensa or the pars flaccida.
- Most important is whether
 - the retraction is totally in view – self cleansing
 - whether there are area out of view that might harbor cholesteatoma
 - clue if marginal be concerned ?active



Please

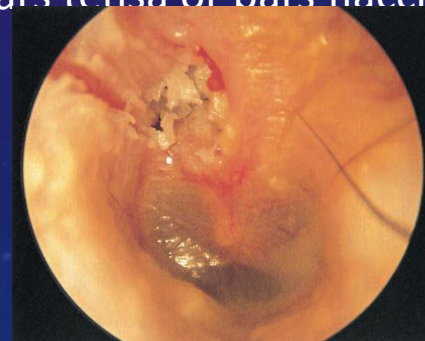
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ACTIVE CHRONIC SQUAMOUS OTITIS MEDIA (CHOLESTEATOMA)

ACTIVE CHRONIC SQUAMOUS OTITIS MEDIA (CHOLESTEATOMA)

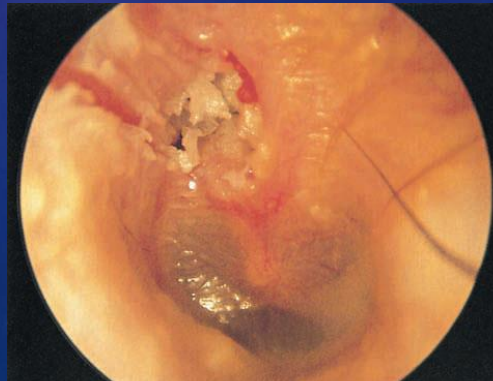
- The hallmark of a cholesteatoma is its retention of keratinous debris
- Cholesteatomas are the end stage of (squamous epithelial) retractions of the pars tensa or pars flaccida
- not self-cleansing,
- retain epithelial debris
- elicit a secondary, inflammatory mucosal reaction.



ACTIVE CHRONIC SQUAMOUS OTITIS MEDIA (CHOLESTEATOMA)

- Can be filled with keratin and be dry,
- Or active bacterial infection – malodorous otorrhoea.

- Cholesteatomas are potentially dangerous
 - potential to incite resorption of bone,
 - leading to intra-temporal or intracranial complications.



ACTIVE CHRONIC SQUAMOUS OTITIS MEDIA

- Presentation
 - Foul smelling otorrhoea
 - Hearing impairment
 - Crust over the attic often mistaken as wax
- Examination under microscope or using an oto-endoscope
- Investigations:
 - PTA
 - CT temporal bone –
 - to study anatomy and extent of disease
 - complications

ACTIVE CHRONIC SQUAMOUS OTITIS MEDIA MANAGEMENT

- The aims of management - to relieve the patient's symptoms and to minimize the risks of complications of the disease.
- **Surgical removal is the only effective treatment for cholesteatoma.**
- Surgery – Mastoidectomy
 - Open cavity – canal wall down mastoidectomy
 - Close cavity – Combined approach mastoidectomy
- If identified please refer to ENT early.
- Antibiotic treatment alone is NOT effective

NASAL PATHOLOGY

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NASAL VESTIBULITIS

- Staphylococcal infection of the nasal hair follicles
- Involves Danger area of the face
- Extremely painful
- Treatment
 - Needs referral to Ent for admission
 - IV antibiotics
 - Analgesics
 - Topical antibiotic cream



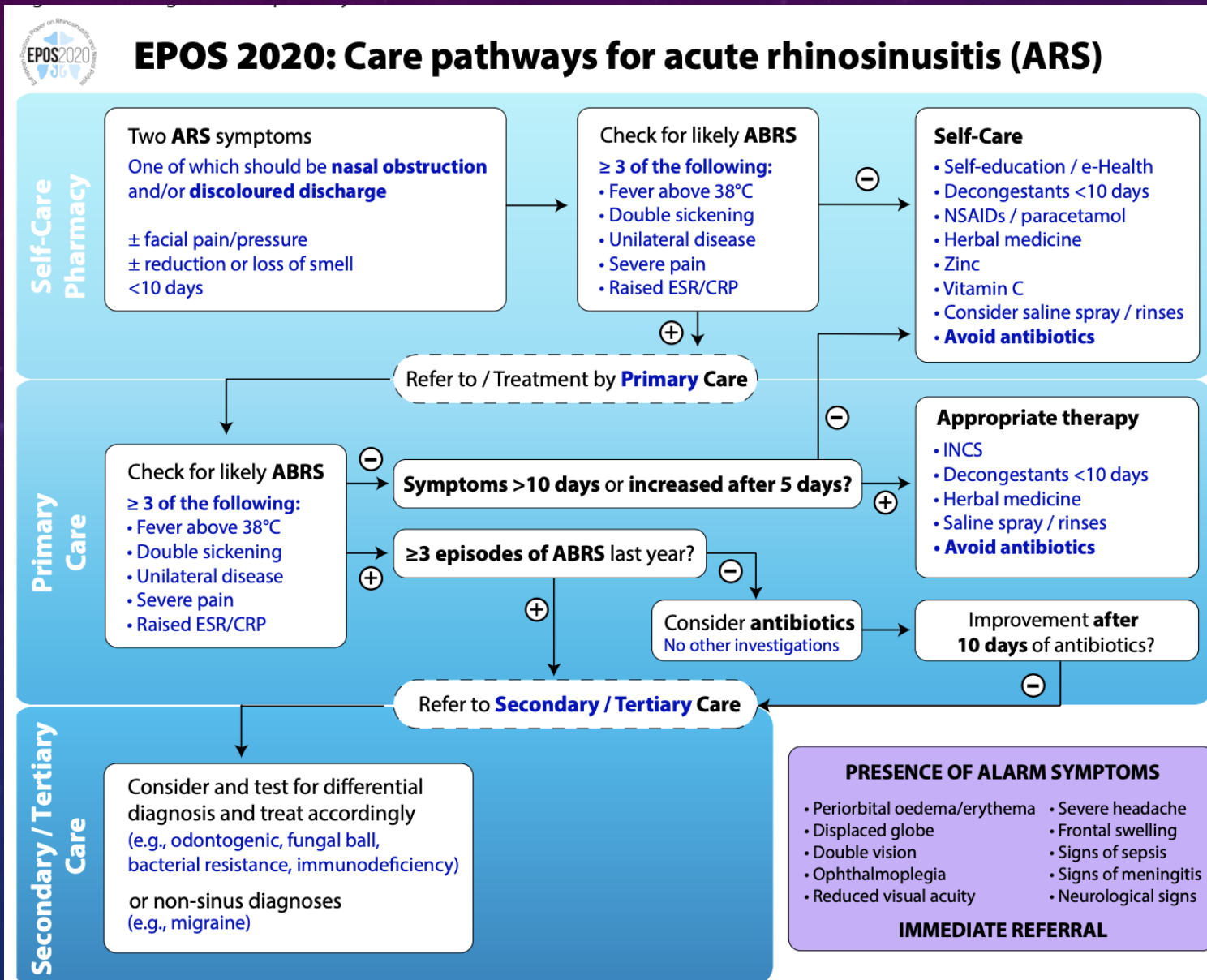
INTRANASAL POLYPS

- Differentiate hypertrophic inferior turbinates from intranasal polyps
- Allergic polyps are usually bilateral, multiple and pale
- If Unilateral polyp – early referral to ENT

SINUSITIS

- Acute Rhinosinusitis
- Chronic Rhinosinusitis(with/without polyposis) in adults and children
- Please refer next slides for primary care advice as per EPOS 2020 guidelines
- INCS(intranasal corticosteroids) when prescribed long term- consider mometasone or fluticasone fuorate due to less side effects and systemic absorption.
- Normal saline/ salt water nasal douching is recommended

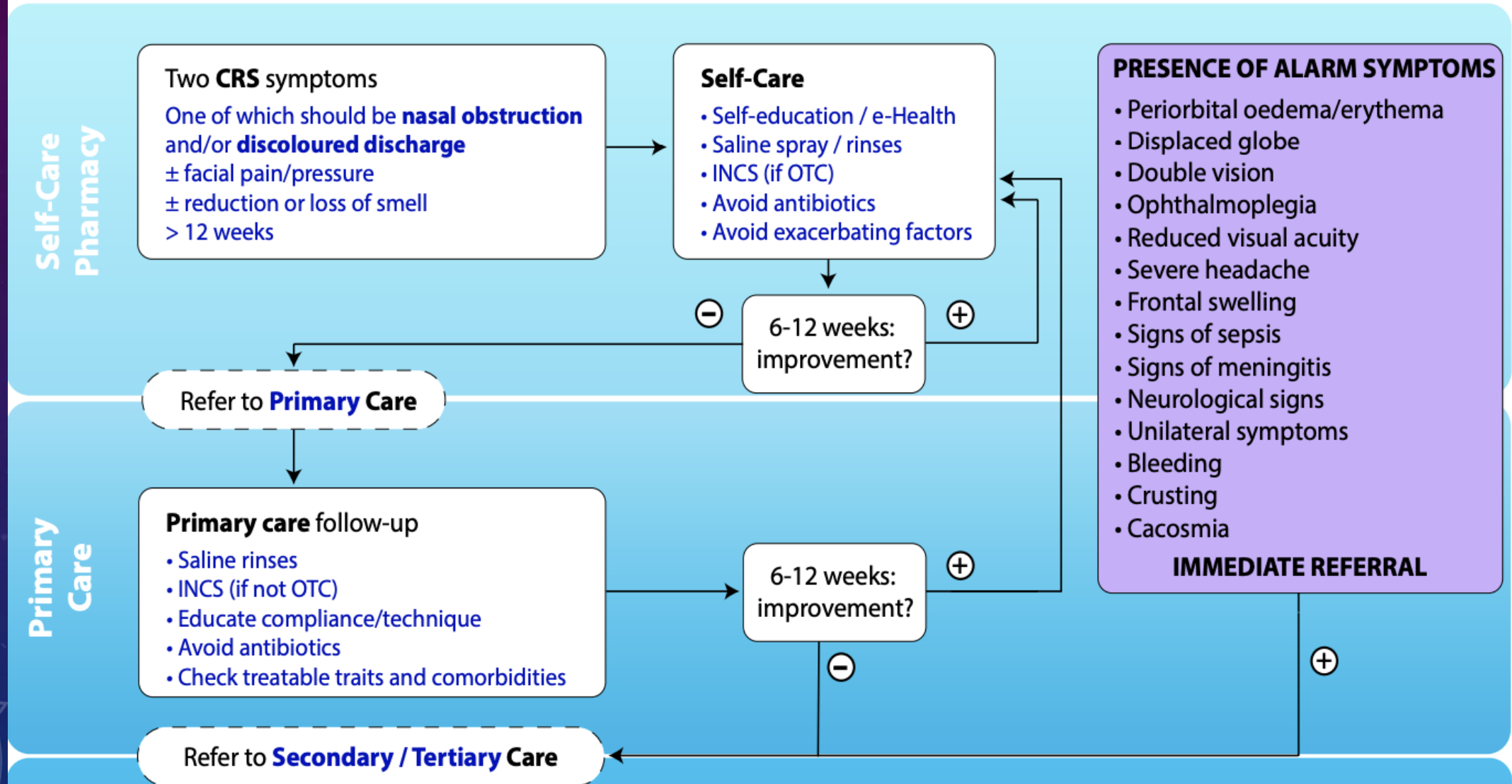
ACUTE RHINOSINUSITIS



CHRONIC RHINOSINUSITIS



EPOS 2020: Care pathways for CRS



EPOS 2020: Care pathways for Paediatric CRS

Self-Care
Pharmacy

Two **CRS** symptoms
One of which should be **nasal obstruction**
and/or **discoloured discharge**
± facial pain/pressure
± cough
> 12 weeks

Self-Care

- Self-education / e-Health
- Nasal hygiene
- Saline spray / rinses
- INCS if OTC
- NSAIDs / Paracetamol

PRESENCE OF ALARM SYMPTOMS

- Periorbital oedema/erythema
- Displaced globe
- Double vision
- Ophthalmoplegia
- Reduced visual acuity
- Severe headache
- Frontal swelling
- Signs of sepsis
- Signs of meningitis
- Neurological signs
- Unilateral symptoms
- Bleeding
- Crusting
- Cacosmia

IMMEDIATE REFERRAL

Differential Diagnosis

- Adenoid hypertrophy
- (non-)Allergic rhinitis
- Common colds
- Primary CRS
- Secondary CRS
- CF
- PCD
- PID
- ...

Primary
Care

Examination of ears, nose and throat

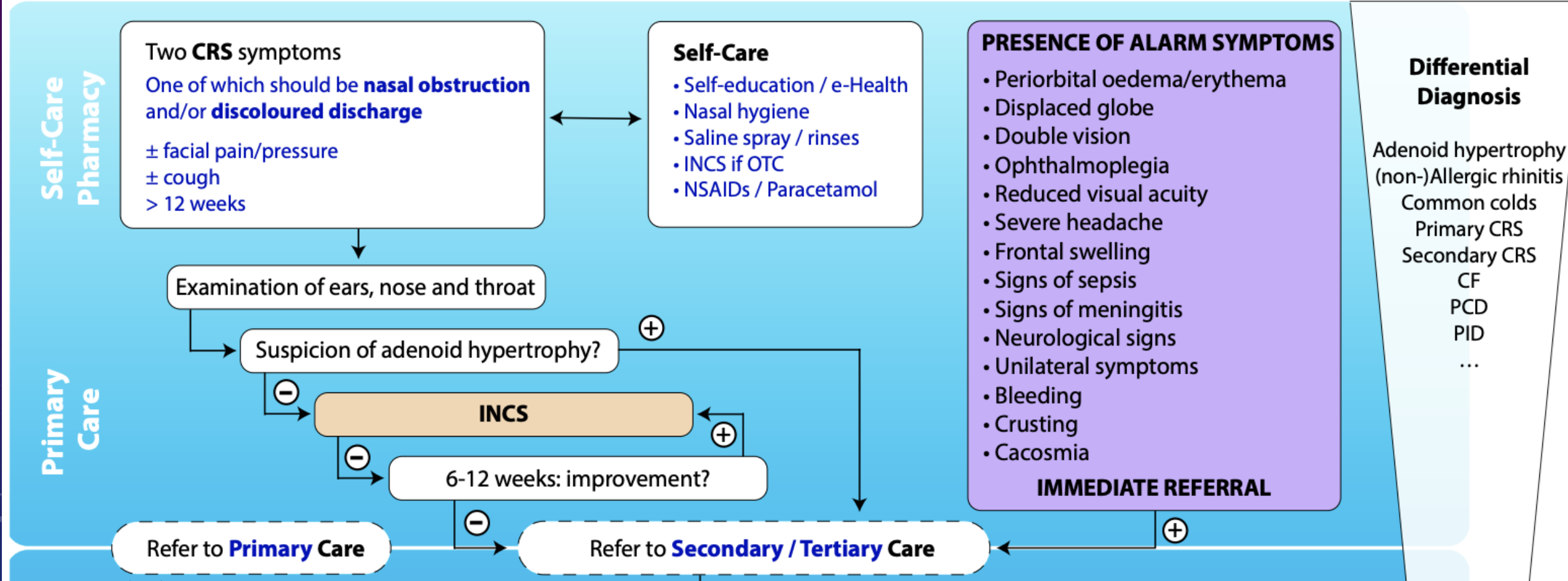
Suspicion of adenoid hypertrophy?

INCS

6-12 weeks: improvement?

Refer to **Primary Care**

Refer to **Secondary / Tertiary Care**



ALLERGIC RHINITIS

- Paroxysmal sneezing/ watery rhinorrhoea, nasal itching and stuffiness
- Seasonal / Perennial
- Genetically predisposed – often associated with other atopic manifestations- BA, nasal polyps
- Treatment
 - Avoid allergen
 - INCS(intranasal corticosteroids)/ Antihistamine sprays
 - Oral Antihistamines (Cerizine/ Fexofenadine/ Loratidine)
 - Oral anti leukotrienes (Montelukast)
- **Avoid topical decongestants – cause rhinitis medicamentosa**

EMERGENCY MANAGEMENT OF EPISTAXIS

- First aid – Sit the patient UPRIGHT and pinch the nose for 10 mins
- If bleeding persists –
 - Anterior nasal bleeds – nasal pack with vaseline /ribbon gauze
 - Posterior bleeding – insert foley catheter in nasopharynx
 - Transfer to ENT
- In elderly –
 - Check BP, elicit medication history(warfarin, anti platelets etc)
 - Restart antihypertensives if stopped
- Minor bleeds/ if stopped spontaneously
 - Decongestants drops/ antihistamines
 - Topical antibiotics to Little's area (especially in children)

NASAL FOREIGN BODIES

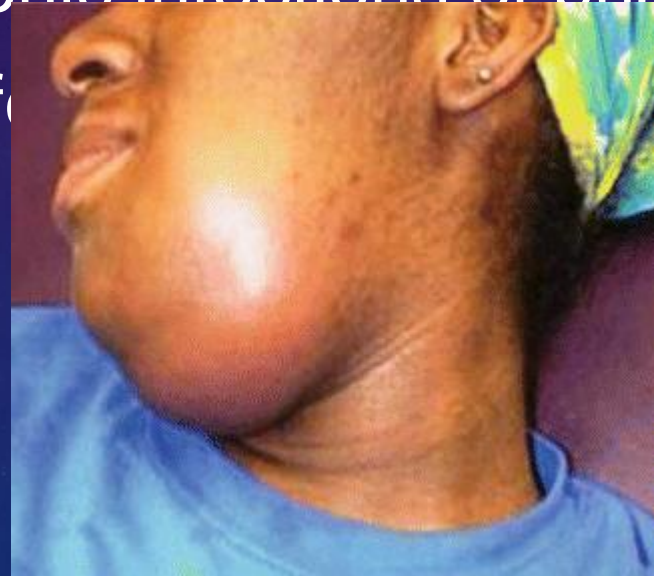
- Needs to be removed under direct vision
- Do not push the foreign body further into the nasopharynx
- Do not attempt to remove FB from children as they may give us only one chance.
- May need sedation or restraining children
- Button battery in the nasal cavity is a surgical emergency

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CONDITIONS OF THE THROAT

INFECTIVE

- Acute and chronic infections of pharynx
- Neck space infections



Tonsillitis



significant causative agents:

- | beta-haemolytic streptococci (groups A, C and G)
- | adenoviruses
- | Epstein-Barr virus

other causative agents:

- | various bacteria and viruses which are rare and with little significance on treatment

Complications

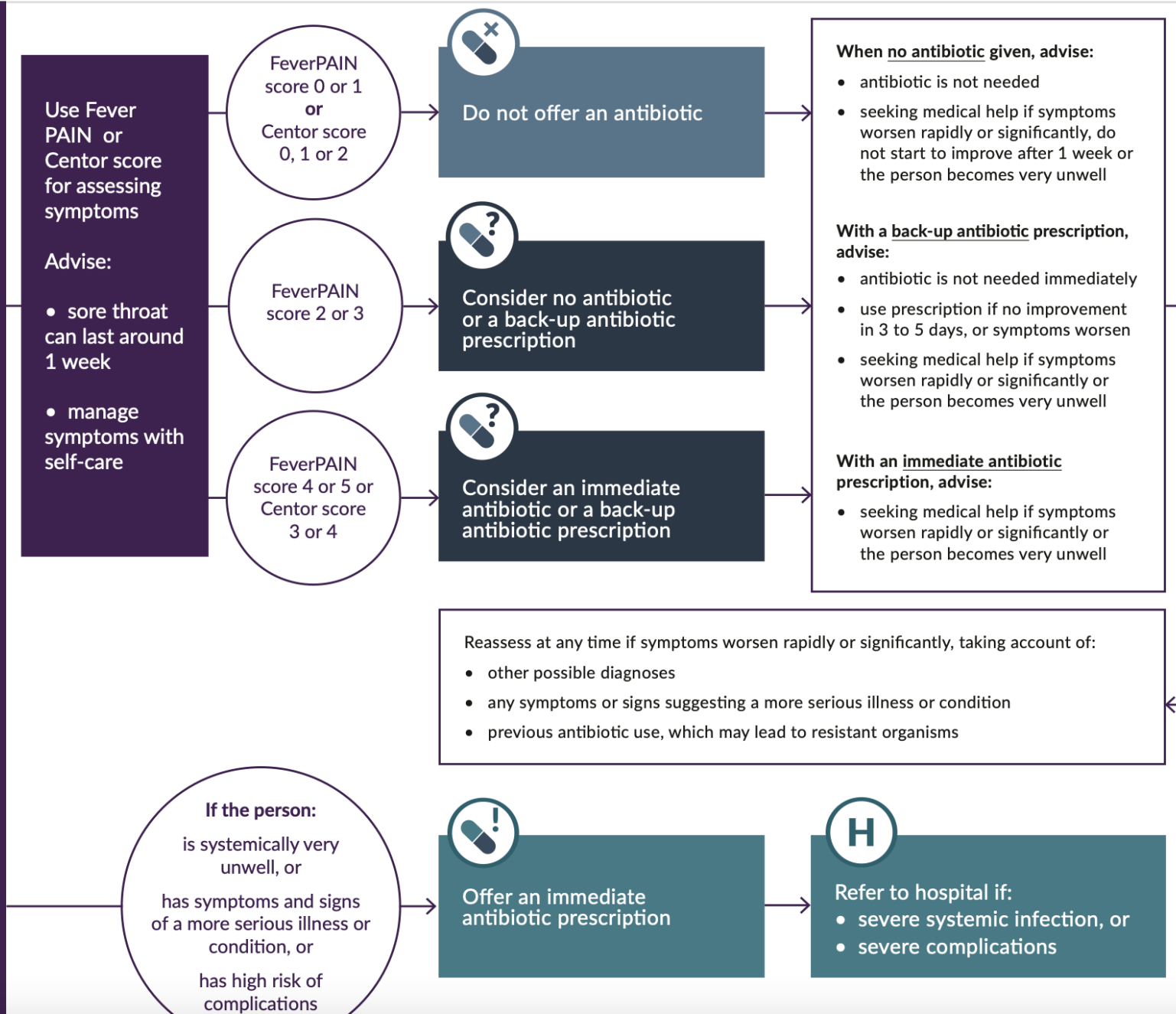
- **Chronic tonsillitis** with recurrent acute attacks
- **Peritonsillar abscess (quinsy)**
- **Parapharyngeal abscess**
- **Cervical abscess** due to suppuration of jugulodigastric lymph nodes.
- **Acute otitis media**
- **Rheumatic fever** Often seen in association with tonsillitis due to Group A beta-haemolytic Streptococci.
- **Acute glomerulonephritis**
- **Subacute bacterial endocarditis** in a patient with valvular heart disease streptococcus viridans infection.

TREATMENT

- Hydration and rest
- *Analgesics*
- *Antimicrobial therapy*. Most of the infections are due to Streptococcus and penicillin is the drug of choice.
- Patients allergic to penicillin can be treated with Clarythromycin.
- Antibiotics should be continued for 5–10 days.
- Salt water gargles
- Steroids?

Sore throat (acute): antimicrobial prescribing

Acute sore throat



Self-care

- Consider paracetamol for pain or fever, or if preferred and suitable, ibuprofen
- Drink adequate fluids
- Some evidence that medicated lozenges can help reduce pain in adults
- No evidence was found for non-medicated lozenges, mouthwashes, or local anaesthetic mouth spray on its own

Evidence on antibiotics

- Antibiotics make little difference to how long symptoms last or the number of people whose symptoms improve
- Withholding antibiotics is unlikely to lead to complications
- Possible adverse effects include diarrhoea and nausea

FeverPAIN score

- Fever, Purulence, Attend within 3 days or less, Severely Inflamed tonsils, No cough or coryza
1 point for each

Centor score

- Tonsillar exudate, Tender anterior cervical lymphadenopathy or lymphadenitis, History of fever (>38°C), No cough
1 point for each

Sore throat (acute): antimicrobial prescribing

NICE National Institute for Health and Care Excellence

Choice of antibiotic: adults aged 18 years and over

Antibiotic ¹	Dosage and course length for adults
First choice	
Phenoxymethylpenicillin	500 mg four times a day or 1000 mg twice a day for 5 to 10 days Five days of phenoxymethylpenicillin may be enough for symptomatic cure, but a 10-day course may increase the chance of microbiological cure
Alternative first choice for penicillin allergy or intolerance (for people who are not pregnant)	
Clarithromycin	250 mg to 500 mg twice a day for 5 days
Alternative first choice for penicillin allergy in pregnancy	
Erythromycin	250 mg to 500 mg four times a day or 500 mg to 1000 mg twice a day for 5 days Erythromycin is preferred if a macrolide is needed in pregnancy, for example, if there is true penicillin allergy and the benefits of antibiotic treatment outweigh the harms. See the Medicines and Healthcare products Regulatory Agency (MHRA) Public Assessment Report on the safety of macrolide antibiotics in pregnancy
¹ See the BNF for appropriate use and dosing in specific populations, for example, hepatic impairment, renal impairment, pregnancy and breast-feeding.	

Choice of antibiotic: children and young people under 18 years

Antibiotic ¹	Dosage and course length for children and young people ²
First choice	
Phenoxymethylpenicillin	1 to 11 months: 62.5 mg four times a day or 125 mg twice a day for 5 to 10 days 1 to 5 years: 125 mg four times a day or 250 mg twice a day for 5 to 10 days 6 to 11 years: 250 mg four times a day or 500 mg twice a day for 5 to 10 days 12 to 17 years: 500 mg four times a day or 1000 mg twice a day for 5 to 10 days Five days of phenoxymethylpenicillin may be enough for symptomatic cure, but a 10-day course may increase the chance of microbiological cure
Alternative first choice for penicillin allergy or intolerance (for people who are not pregnant)	
Clarithromycin	1 month to 11 years: Under 8 kg: 7.5 mg/kg twice a day for 5 days 8 to 11 kg: 62.5 mg twice a day for 5 days 12 to 19 kg: 125 mg twice a day for 5 days 20 to 29 kg: 187.5 mg twice a day for 5 days 30 to 40 kg: 250 mg twice a day for 5 days or 12 to 17 years: 250 mg to 500 mg twice a day for 5 days
Alternative first choice for penicillin allergy in pregnancy	
Erythromycin	8 to 17 years: 250 mg to 500 mg four times a day or 500 mg to 1000 mg twice a day for 5 days Erythromycin is preferred if a macrolide is needed in pregnancy, for example, if there is true penicillin allergy and the benefits of antibiotic treatment outweigh the harms. See the Medicines and Healthcare products Regulatory Agency (MHRA) Public Assessment Report on the safety of macrolide antibiotics in pregnancy

WHEN TO REFER FOR TONSILLECTOMY

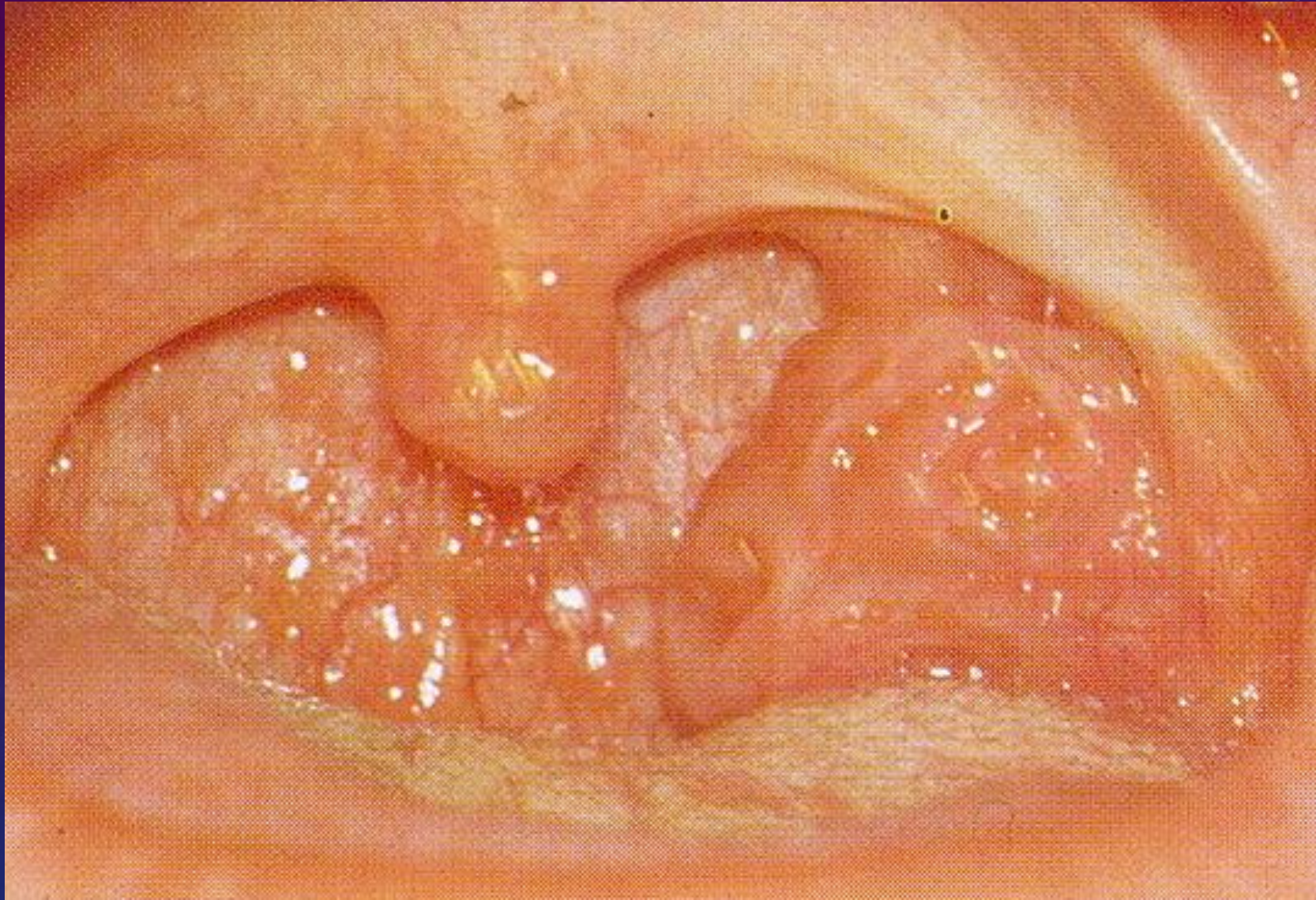
- Recurrent infections: 3 per year for 3 years, 5 per year for 2 years, 7 or more in 1 year, or greater than 2 weeks of school or work missed in 1 year
- Hypertrophy causing upper airway obstruction (sleep disordered breathing or frank sleep apnea) or causing deglutition problems
- Peritonsillar abscess- 2nd
- Suspicion of malignancy, either unilateral enlarged or search for unknown primary
- Recurrent tonsillitis causing febrile seizures
- Diphtheria carrier
- Treatment of early-stage cancer (often performed with robotic assistance, TORS)



Enlarged tonsils



Tonsillar cyst



Unilateral enlarged tonsils



Cancer of the tonsils

NEOPLASTIC

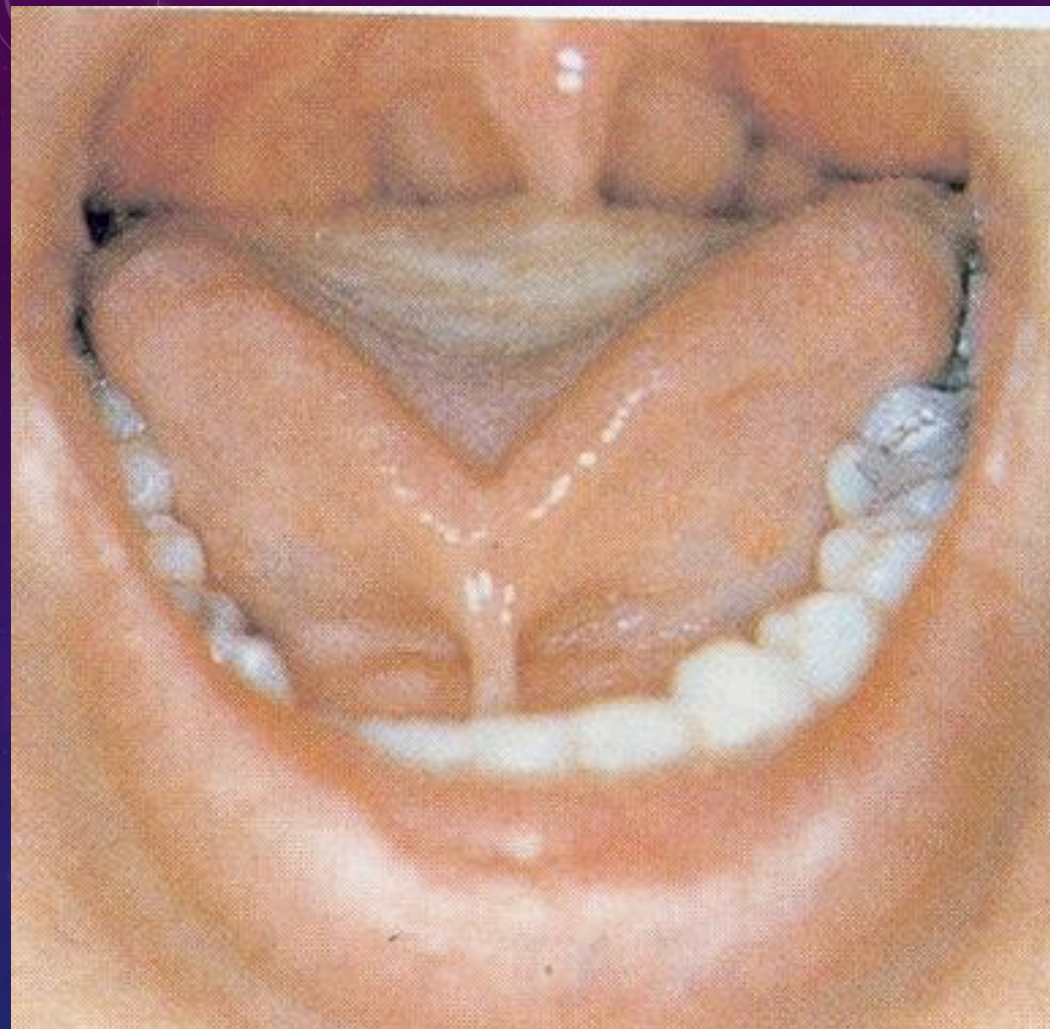
- Benign tumours
- Malignant tumours



- In the oral cavity, most tumours are malignant and of these 95% are squamous cell carcinomas (SCCs).
- The patient may present with a lump in the mouth or with an ulcer that may result in odynophagia. Oral cavity Ca is often identified on examination.
- Dysphagia can be caused by tongue fixation.
- Early referral to ENT needed.



Oral thrush - Candidiasis
Treatment - Nystatin



Tongue tie
Refer to Ent by 1 year of age

LUDWIG'S ANGINA

- Infection of submandibular space
- Commonly following dental infections
- Life threatening
- Needs urgent transfer to an ENT / OMF unit
- Systemic antibiotics and steroids
- Incision and drainage of abscess.
- Tracheostomy, if airway is endangered.

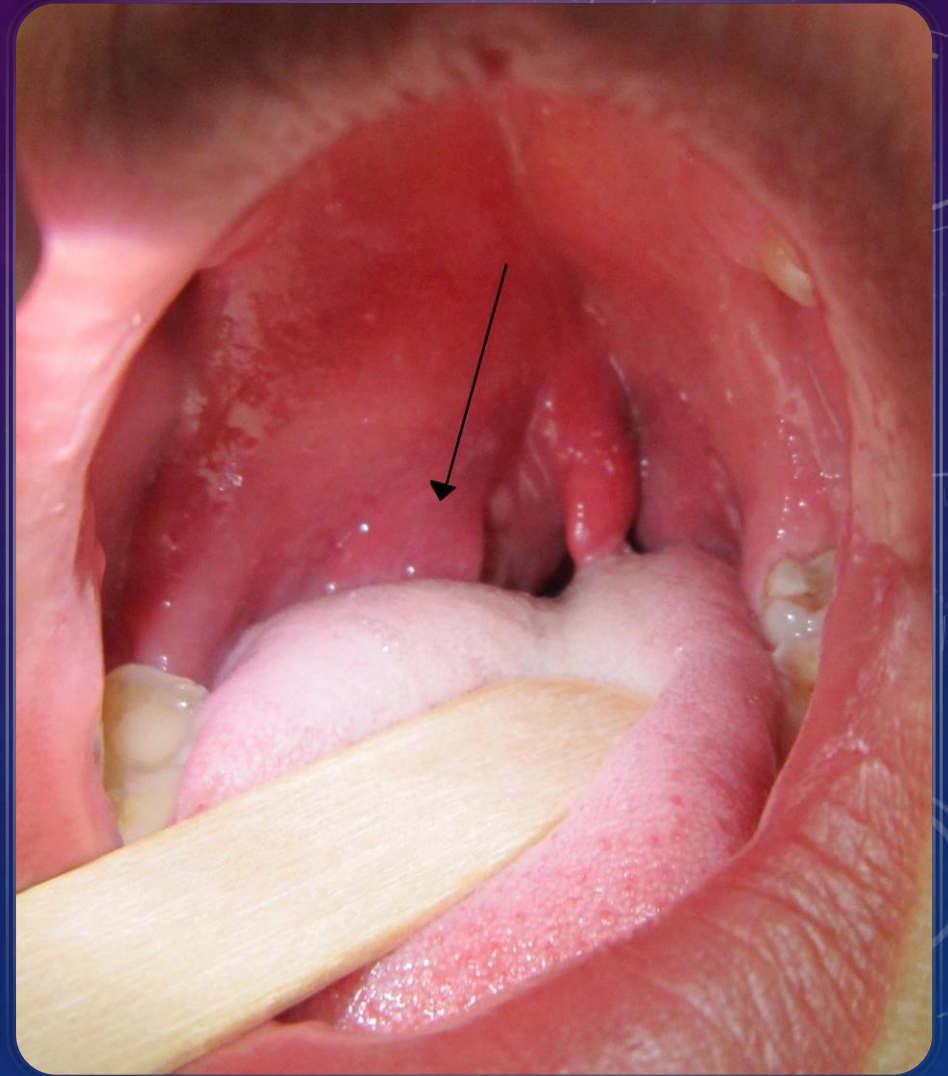


PERITONSILLAR ABSCESS (QUINSY)

- collection of pus in the peritonsillar space which lies between the capsule of tonsil and the superior constrictor muscle.
- **CLINICAL FEATURES**
 - Mostly affects adults
 - Unilateral though occasionally bilateral abscesses are recorded. (A) severe pain in throat. Usually unilateral.
 - Odynophagia- cannot even swallow his own saliva which dribbles
 - *“Hot potato voice.”*
 - Foul breath due to sepsis in the oral cavity and poor hygiene.
 - Ipsilateral earache. This is referred pain via CN IX which supplies both the tonsil and the ear.
 - Trismus due to spasm of pterygoid muscles which are in close proximity to the superior constrictor.

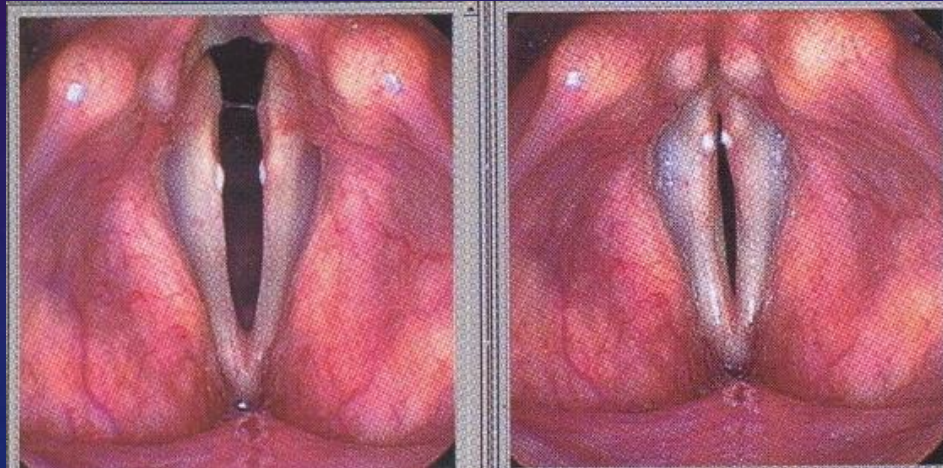
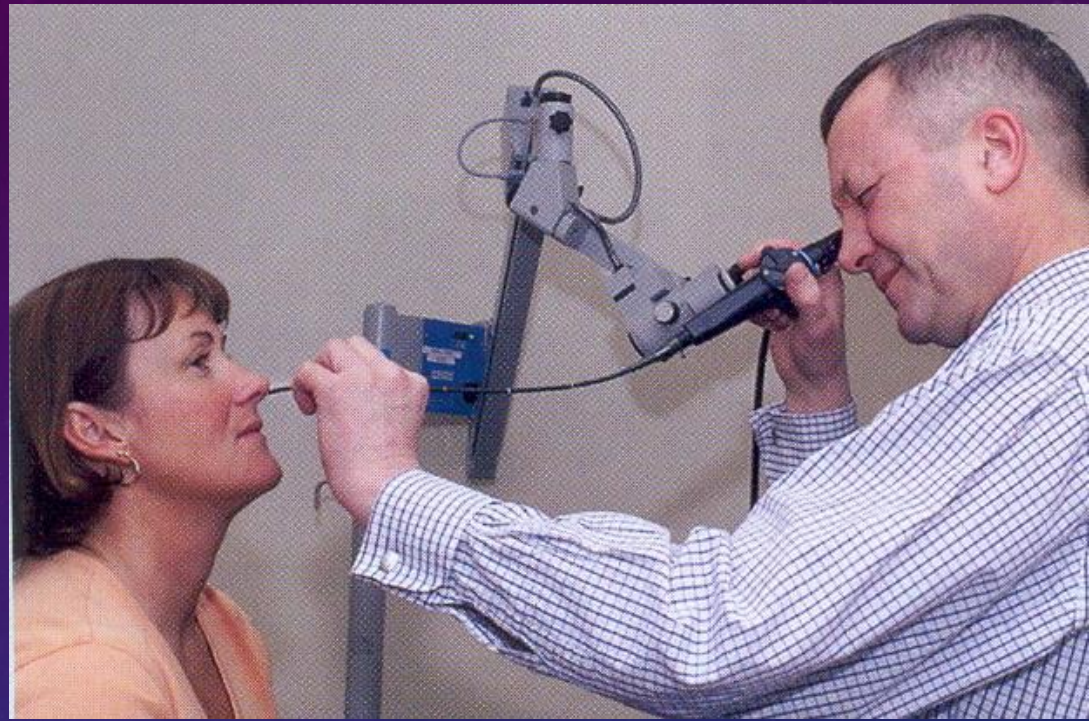
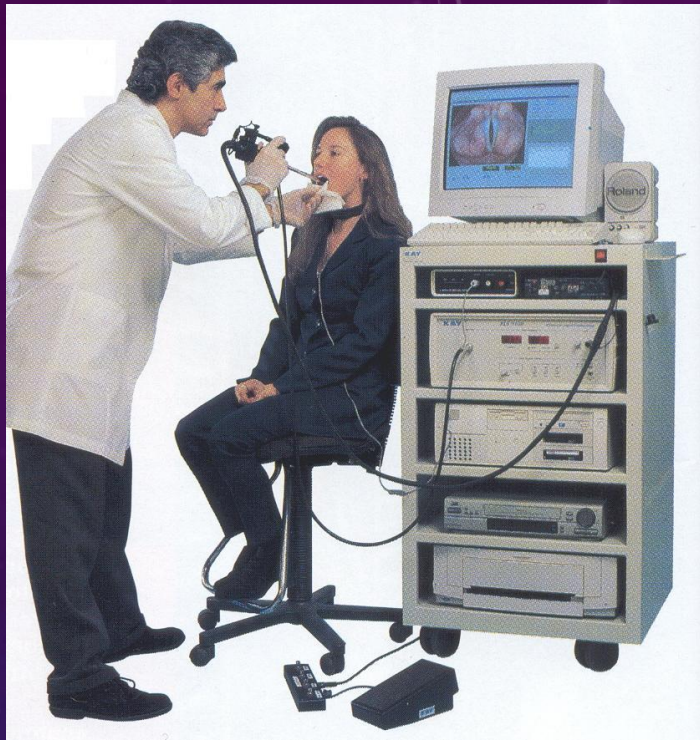
PERITONSILLAR ABSCESS (QUINSY)

- **EXAMINATION**
 - Uvula is swollen and oedematous and pushed to the opposite side.
 - Bulging of the soft palate and anterior pillar above the tonsil.
 - Torticollis- Patient keeps the neck tilted to the side of abscess.
-
- Refer to Ent urgently for admission



HOARSENESS OF VOICE

- Many etiologies
- Common causes due to upper respiratory tract infections
- Any persistent hoarseness more than 3 weeks should be referred to ENT to rule out sinister pathology



Examination of Vocal cords

Diseases of the salivary glands

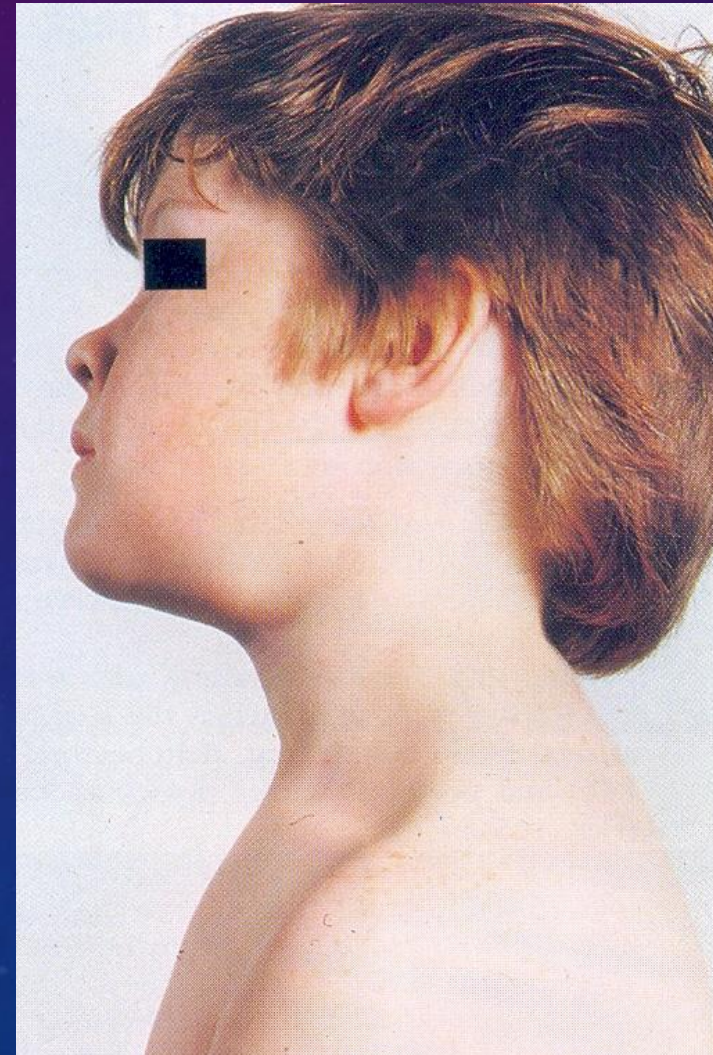
MUMPS (VIRAL PAROTITIS)

It is a viral infection caused by paramyxovirus

- Complications
 - *Orchitis* . Sterility following mumps is rare.
 - *Oophritis*
 - *Pancreatitis*
 - *Aseptic meningitis* or meningoencephalitis
 - *Unilateral sensorineural hearing loss* can occur due to involvement of the labyrinth.
- Management
 - hydration, rest, analgesics and cold or hot compresses over the parotid to relieve pain. Food which encourages salivary flow should be avoided as they cause pain



Mumps



ACUTE SUPPURATIVE PAROTITIS

- In elderly, debilitated and dehydrated patients.
- *Staphylococcus aureus*
- *Management*
 - Antibiotics- Co-amoxyclav
 - Hydration
 - Measures to promote salivary flow
 - Attention to oral hygiene
 - Surgical drainage

FOREIGN BODY IN THE PHARYNX OR OESOPHAGUS



- Most common traumatic cause of dysphagia.
- It is important from the history to determine whether it is a sharp foreign body or a soft food bolus obstruction.
- A variety of foreign bodies are ingested by children and patients with learning difficulties, the most common being coins.
- History of Button Battery ingestion is a surgical emergency
- The size and shape of the foreign body will dictate where it lodges
- Refer the patient urgently to ENT

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