Common Urgent ENT Problems

APRIL 4, 2019

GERARD MACDONALD MD FRCS

1

Course Objectives

- A review of common Urgent ENT problems presenting to office and ER
- Clinical Pearls to help you manage in a timely fashion
- Knowing when to refer

2

I do not have any Conflicts of Interest

3

Top Ten List Of Urgent Calls

- 1.Acute Otitis Externa
- 2. Sudden Hearing Loss
- 3.Facial Palsy
- 4.Salivary Gland Stone /Infection
- 5.Peritonsillar Abscess
- 6.Neck Abscess
- 7.Nosebleeds
- 8.Hoarseness
- 9.Foreign Bodies Ear/Nose
- 10. Acute Vertigo

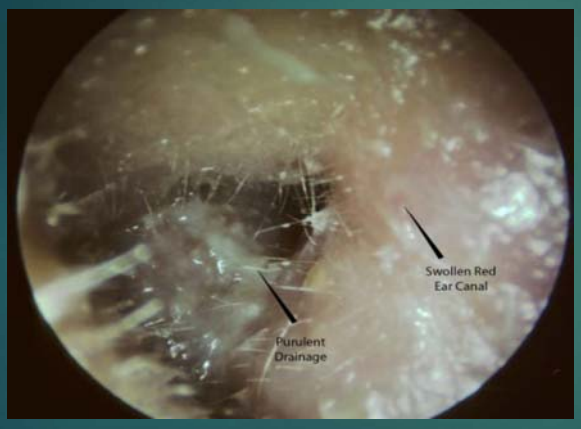
4

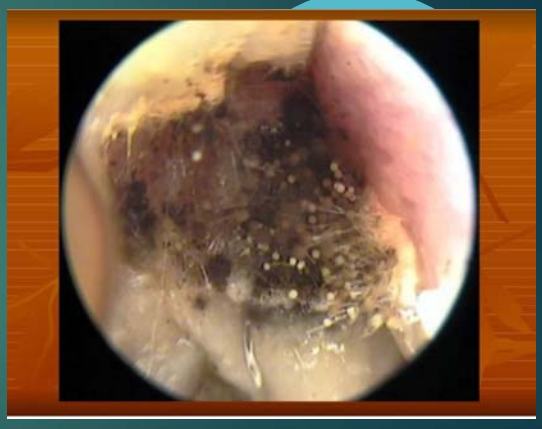
Acute Otitis Externa

- Commonly associated with swimming (swimmer's ear)
- Common in diabetics and habitual Q-tip Users
- Usual presenting symptoms are itching, discharge, pain and swelling.
- More severe symptoms can include severe pain, parotid swelling,trismus and cellulitiis
- Most common organism is Pseudomonas Aeruginosa
- May go on to develop secondary otomycosis if frequent use of topical antibiotics.
- Malignant External Otitis rare but serious

5

Acute Otitis Externa





6

Acute Otitis Externa - Treatment

- Debridement/Suctioning ? Culture
- Avoid syringing
- Ototopicals : Tobradex, Sofracort, Ciprodex
- Otowick if canal swollen shut
- Oral Antibiotic (Cipro) and single dose Steroid if severe
- When to refer : Unrelenting pain and swelling, facial nerve weakness,dysphagia , fever

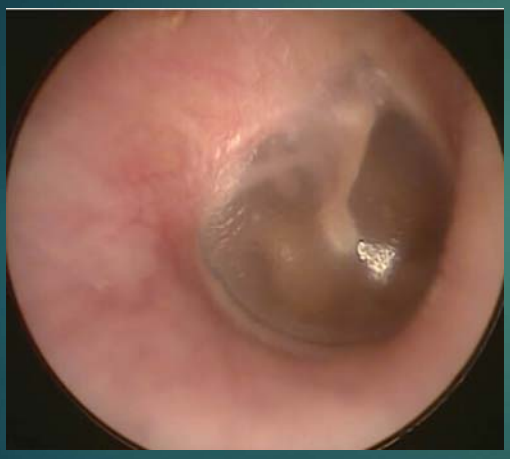
7

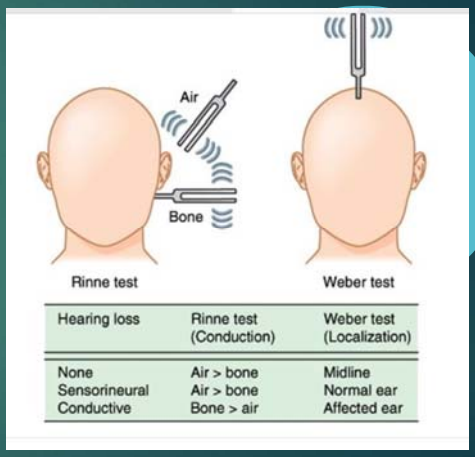
Sudden hearing Loss

- UNEXPLAINED sudden sensorineural hearing loss occurring over 3 days
- Not AOM, trauma, acoustic trauma , ototoxicity
- Often confused with ETD , “fluid”
- Poorer outcome if not recognized and treated.
- Etiology unclear but includes viral,vascular, cochlear membrane rupture
- May include tinnitus,vertigo

8

Sudden Hearing Loss Loss

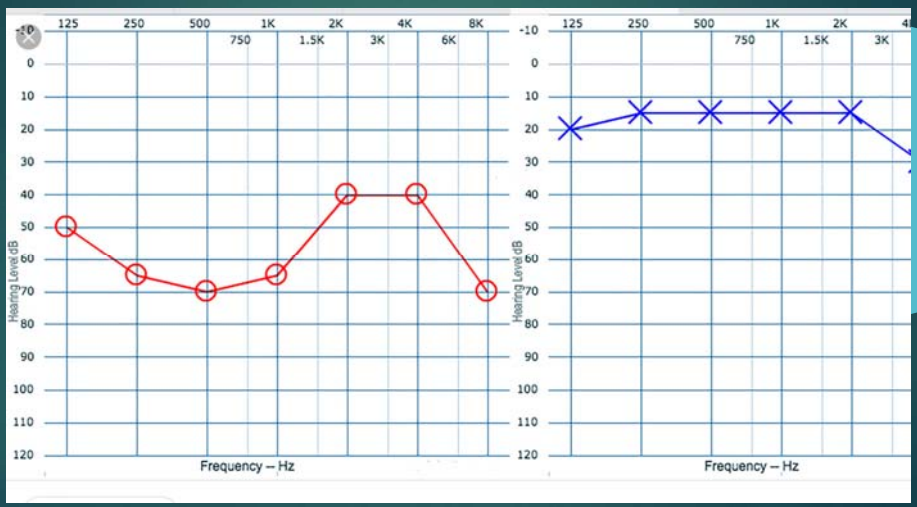




Hearing loss	Rinne test (Conduction)	Weber test (Localization)
None	Air > bone	Midline
Sensorineural	Air > bone	Normal ear
Conductive	Bone > air	Affected ear

9

Sudden hearing Loss



10

Sudden Hearing Loss - Treatment

- Requires high index of suspicion
- Urgent Audiogram and ENT Referral (phone)
- Start high dose oral steroids if any doubt
- Prednisone 60 mg daily x 1 week,then taper
- ENT may consider intratympanic steroids/ MRI
- NB Prognosis depends on early recognition
- When to Refer : all cases

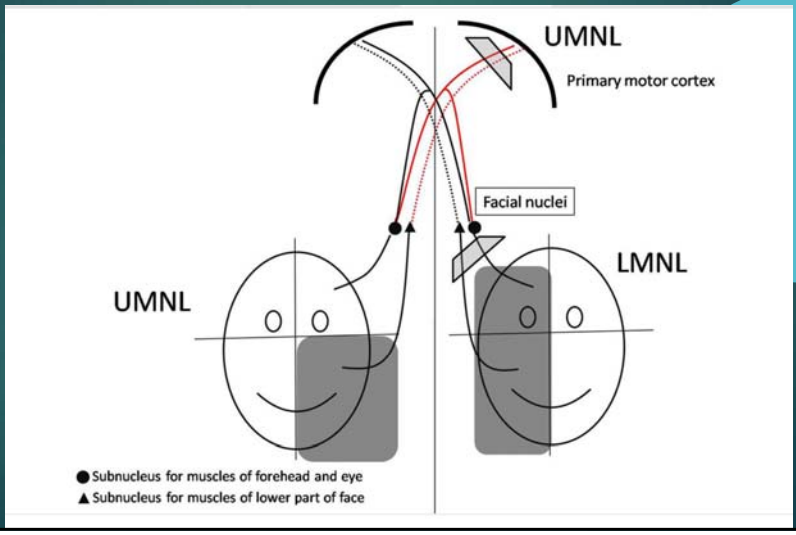
11

Acute Facial Palsy

- Sudden onset of unilateral facial weakness or paralysis over several days. Bilateral rare.
- Idiopathic –Bell's Palsy
- Ramsey- Hunt Syndrome-with herpes zoster oticus
- Symptoms can include lack of eye closure, drooping mouth, drooling,dysarthria, hypacusis , alters taste,ear pain.
- Delayed onset over weeks –secondary causes eg Lyme's, neuroma , Melker-Rosenthal Syndrome

12

Acute Facial Palsy – Upper or Lower Motor Neuron ?



13

Acute Facial Palsy

- Clinical work up not usually required in acute phase. (Stapedius reflex may be of prognostic value)
- Treatment includes eye care (lubricant,patch) and oral steroids -Prednisone 60mg taper over 10 days
- Role of antivirals ,physical therapy unproven.
- When to refer : failure to improve within 3 months

14

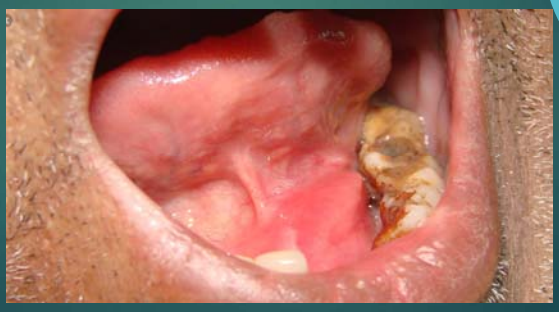
Salivary Gland Swelling

- May be acute, recurrent or chronic
- Multiple causes but more common with calculi, dehydration, poor oral hygeine, and in diabetics.
- Rarer causes include tumours, Sjogren's, Sarcoidosis,mumps

15

Salivary Gland Swelling

- Symptoms can include fluctuant swelling with eating or chewing, pain, redness , cellulitis
- Parotid vs. Submandibular , Uni-vs bilatera'. Binaural palpation of Wharton's (submandibular) and Stenson's (parotid) ducts : clear, pus, stone.



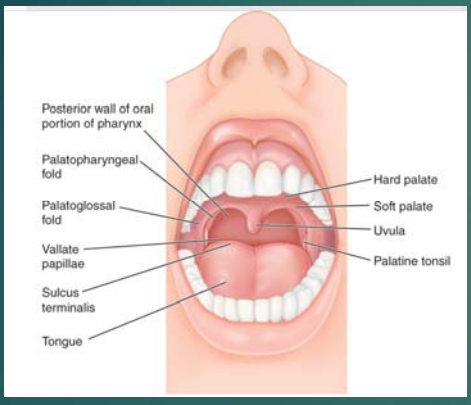
16

Acute Salivary Swelling

- Rarely needs urgent investigation and initial treatment is conservative and expectant as usually resolves within 24-48 hrs.
- "MASH " treatment. Consider staph/strep coverage if persistent > 48 hrs.
- When to Refer : Persistent swelling or recurrent , complications with fever /neck swelling

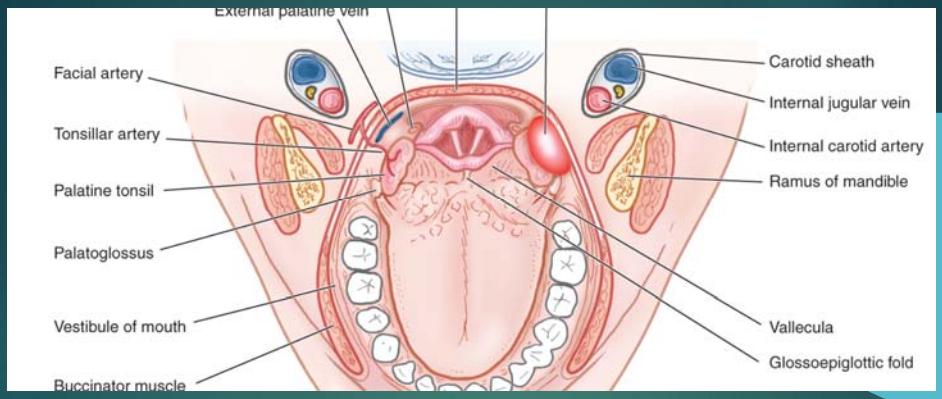
17

Peritonsillar Space - Anatomy



- BOUNDARIES
- Anterior and PosteriorPillars
- Tonsil
- Superior Consrictor Muscle

18



Peritonsillar Space - Anatomy

NB Carotid sheath is 2 cm posterior and lateral to tonsillar pillars

19

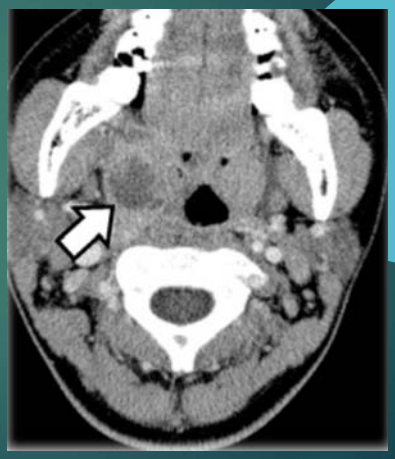
Peritonsillitis/Peritonsillar Abscess

- Unilateral sore throat, swelling, trismus,hot potato voice,often without fever or elevated WBC, and usually negative strep screen.
- History < 72 hours rarely PTA. Often with no prior history of recurrent sore throats.
- Cultures usually mixed bag of anaerobes and not helpful in acute situation

20

Peritonsillitis/Peritonsillar Abscess

- Role of Ultrasound/ CT scans ?



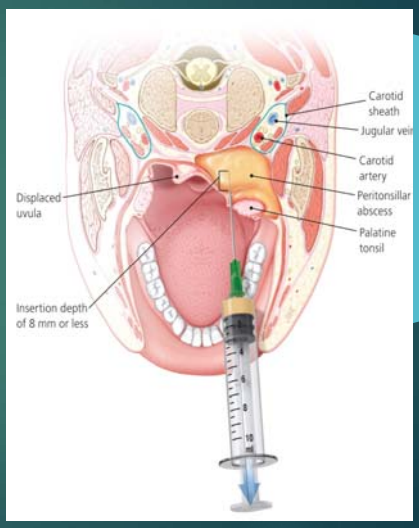
21

Peritonsillitis/Peritonsillar Abscess

- IV Hydration
- Clavulin
- Rocephin 1-2 grams IV q 24h 3-7 days and Flagyl 500 mg po q8h 7days
- Dexamethasone 10-20 mg IV one dose
- Clindamycin no longer recommended due to resistance
- Aspiration/ I & D

22

Peritonsillitis/Peritonsillar Abscess



23

Peritonsillitis/Peritonsillar Abscess

- Equipment : Headlight,suction, tongue depressor, headrest,Lidocaine topical/injectable, 5 cc syringe, #20,#22 1 1/2” needles, #11 pointy blade, small curved haemostat.
- Upper/ middle pole areas only, never lower and stay medial to pillars
- No more than 1.5 cm deep

24

Peritonsillitis? Peritonsillar Abscess

- **When to Refer :**
- Failure of treatment within 24-48 hrs
- Airway concerns
- Deep neck infection
- Painless enlargement of Peritonsillar area- tumour, tortuous carotid

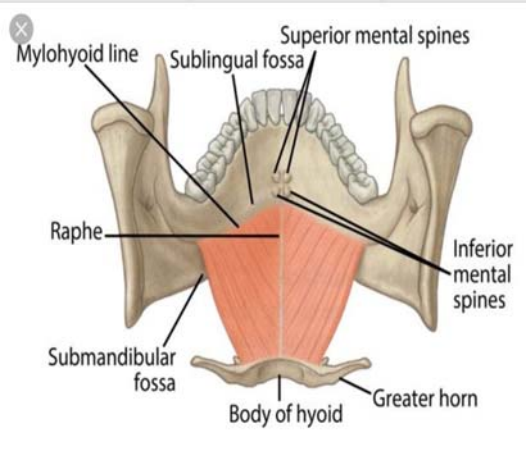
25

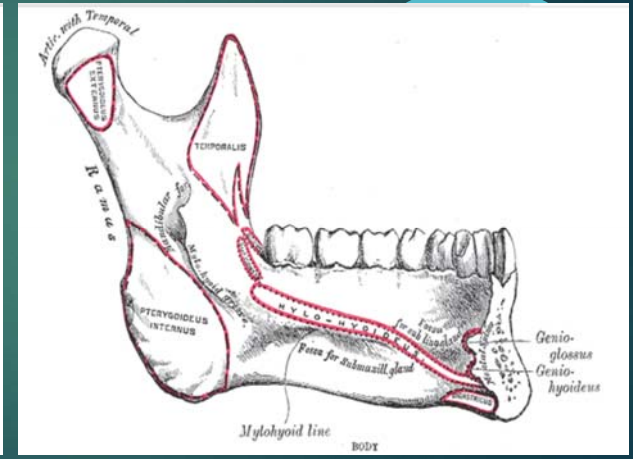
Deep Neck Infections

- Ludwigs' Angina (cellulitis/phlegmon)
- Retropharyngeal abscess
- Parapharyngeal abcess
- Mandibular Space abscess

26

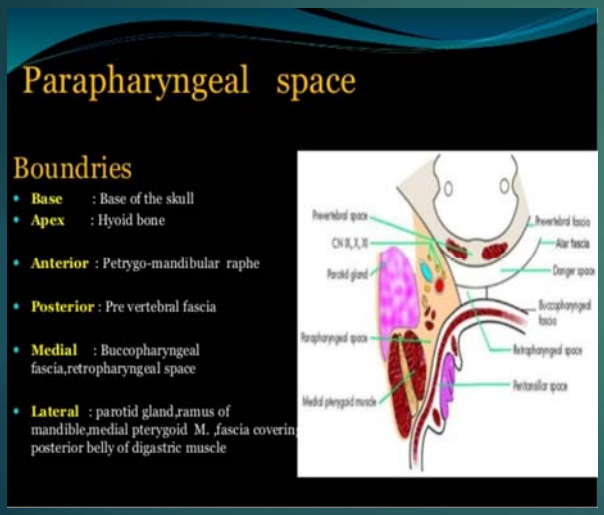
Deep Neck Abscess - Anatomy

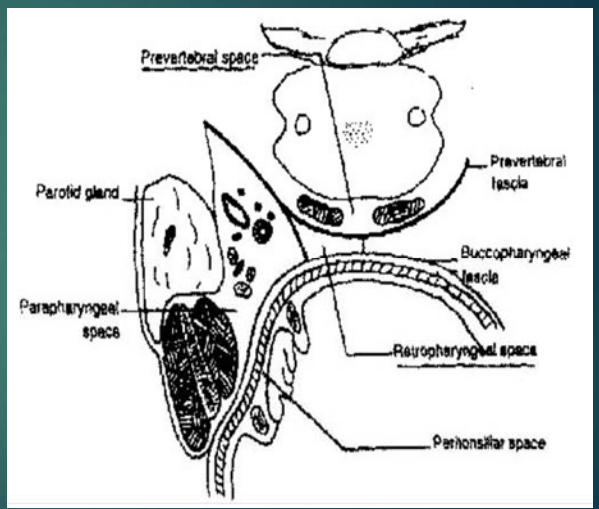




27

Deep Neck Infections - Anatomy

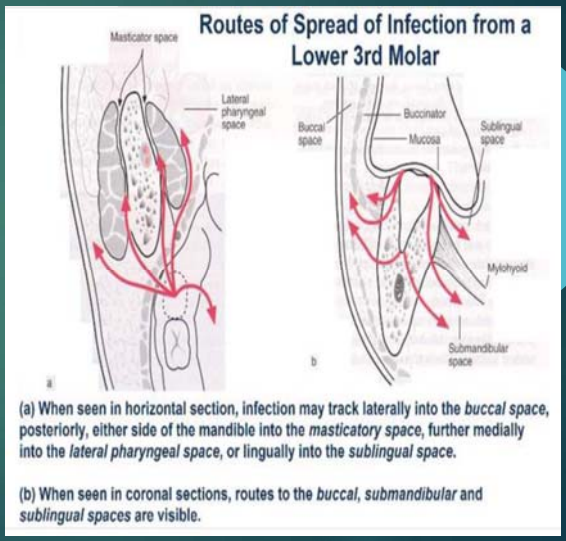




28

Deep Neck Infections

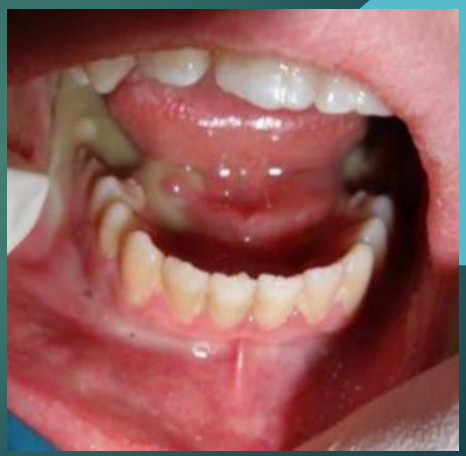
- Complications of dental,pharyngeal and salivary land infections
- Usually mixed bag anaerobic bacteria
- Risk of extension to other neck spaces and mediastinum



29

Deep Neck Infection

- Cardinal Symptoms : neck swelling , cellulitis, odynophagia, hoarseness, strider, fever, SOB
- Beware firm swelling anterior neck, floor of mouth and raised tongue.



30

Deep Neck Infection

- **When to Refer : NOW!**
- CBC, creatinine
- IV Hydration
- Antibiotics : Rocephin and Flagyl: piperacillin/tazobactam,clindamycin
- Urgent contrast neck CT
- Admission/ ? ICU
- Prophylactic intubation/Tracheostomy

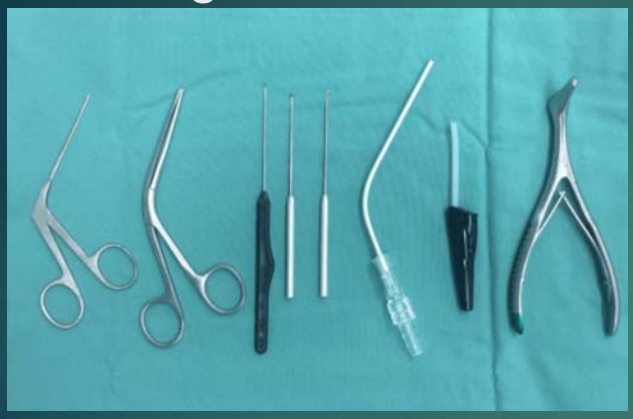
31

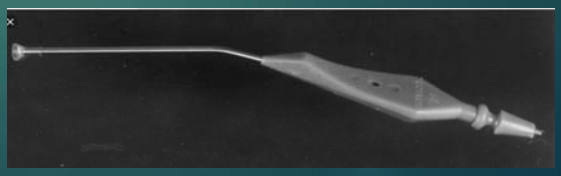
Foreign Bodies Ears/ Nose

- Many ways to skin a cat :
- Suction, Irrigation if non organic (ears)
- Curettes,hooks, balloons
- Positive pressure
- Magnets
- Caution with young children: you only have one chance
- Use of topical decongestant/anesthetic

32

Foreign Bodies Ears/ Nose

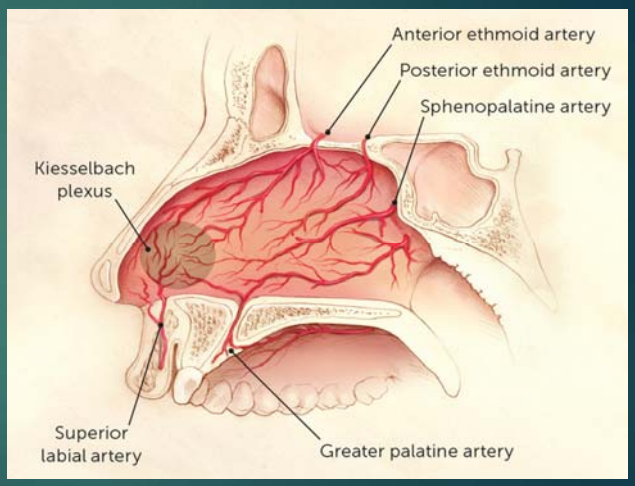




33

Epistaxis

- Mostly anterior
- Mostly septum
- Mostly venous
- Most respond to minimal pressure



34

Epistaxis

- Most commonly seen:
- Dryness
- Nosepickers
- Blood thinners : ASA,Warfarin, Plavix

35

Epistaxis

- Newer agents :
- Xarelto (rivaroxaban)
- Eliquis (apixaban)
- Pradax (dabigatran) –antidote Praxbind
- Fragmin (dalteparin)
- Lovenox (enoxaparin)

36

Epistaxis – set up Epistaxis Tray

- Suction : Fraser tip -at least #9, Yankouer
- Headlight, bayonets, nasal speculum,K-basin
- Topical Lidocaine/Otrivin, Silver nitrate sticks
- Cotton balls, neuro patties
- Packing options: Rapid Rhino (anterior&post), Surgicel,merocel,Vaseline gauze, Foley catheters,Epistaxis,posterior pack.

37

Epistaxis

38

Epistaxis -Treatment

- Where did it start? How much, how often, how long ?
- Visualization (have them blow clots out)
- Use of vasoconstrictor/topical Lidocaine on cotton balls, leave in 5-10 minutes
- Cauterize if possible
- If slow ooze consider rolled Surgicel
- If heavier then packing eg Rapid Rhino

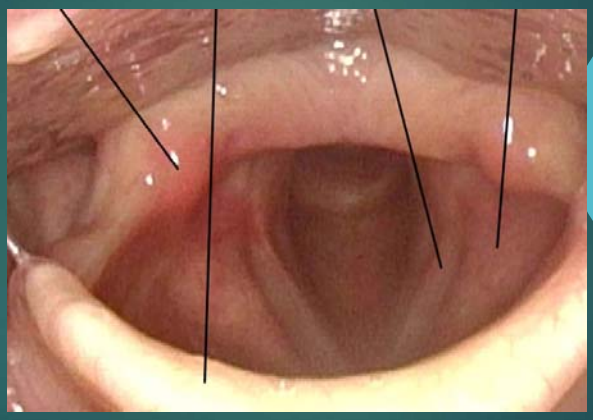
39

Epistaxis - Treatment

- Ancillary treatment :
- Saline,polysporin
- Ice water gargles
- Tranexamic acid
- Consider holding/ reversing blood thinners
- Leave packing in 48-72hrs
- ?Antibiotics
- **When to Refer :** uncontrolled, recurrent,removal

40

Hoarseness



41

Hoarseness

- Most Common causes:
- Postviral, Post URI with harsh cough
- Vocal abuse
- Reflux
- Presbylarnx
- Smoking
- Hypothyroidism

- Less common :
- Vocal cord paralysis
- Tumour
- Muscle Tension Dysphonia
- Functional
- Paradoxical Vocal Cord Movement
- Trauma/intubation

42

Hoarseness

- **When to Refer ? Literature range 2 wk -3 months**
- If benign cause suspected ie viral, cough induced, reflux, vocal abuse then waiting 4 weeks is reasonable
- Role of empiric treatment in absence of direct exam may include voice rest, hydration , trial of PPI's , steroids and tincture of time
- If persisting beyond 4 weeks then refer

43

Hoarseness

- RED FLAGS indicating urgent referral within 2 weeks:
- Rapidly progressive, stridor, dysphasia, odynophagia, fever, neck mass, referred otalgia, esp. in smoker > 10 years

44

Acute Vertigo - History Taking

- True vertigo or not?
- Temporal duration : seconds, minutes ,hours ,days ?
- Temporal sequence : episodic or continuous ?
- Positional Component ?
- Associated Otologic Sx : tinnitus,hearing loss, aural fullness
- Other symptoms : headache, DDDD's
- Other medical History: migraine, MS, TIA's, CV,DM
- Meds

45

Acute Vertigo

- Most common causes:
- Benign Positional Vertigo
- Acute Vestibular Neuronitis
- Meniere's
- Labyrinthitis
- Functional

46

Acute Vertigo - Diagnosis

- Mostly by history and confirmed by exam
- Eye exam : nystagmus, head shake
- CN 2-12
- Cerebellar Function
- Romberg
- Dix- Hallpike
- Hyperventilation

47

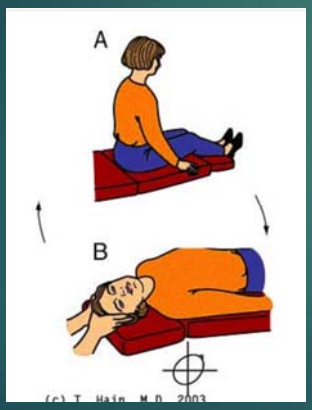
Acute Vertigo

- If there is one type of vertigo to become proficient at, let it be BPV?
- No need for Serc, Head CT ,easily treated Andy out will have satisfied patient.
- History is quite typical
- Dix-Hallpike features:
- Latency, Directional characteristics of nystagmus, brief duration, fatigability.

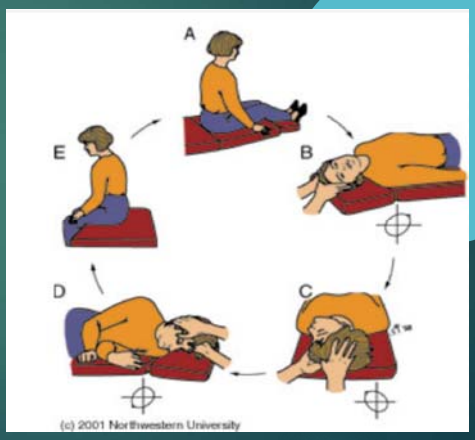
48

Acute Vertigo - BPV

Dix-Hallpike RIGHT EAR



Epley Maneuver RIGHT



49

Thank You !

50