REFERRAL GUIDELINES
EAR, NOSE & THROAT

Referral Form: The GP Referral Template is the preferred referral tool (previously known as the Victorian Statewide Referral Form) – GP Referral Template

This tool is housed in most major clinical software or can be downloaded from http://nhv.org.au/program/11/victorian-statewide-referral-form

Click on category to advance to that page:

Ear
- Recurrent Otitis Media
- Middle Ear Effusion (Glue Ear)
- Ear Drum Perforation
- Chronic Ear Disease
- Tinnitus
- Vertigo
- Sudden Hearing Loss

Throat
- Tonsillitis
- Paediatric OSA
- Adult OSA
- Dysphagia
- Dysphonia
- Paediatric speech disturbance

Other
- Facial palsy

Nose
- Chronic/recurrent Rhino-sinusitis
- Nasal congestion/Obstruction
- Recurrent Epistaxis
- Nasal reconstruction/ Rhinoplasty
- Nasal congestion/Obstruction

ENT Head & Neck Oncology
- Suspicious H & N malignancies

URGENT REFERRALS
- Sudden Hearing loss – link to above
- Very severe OSAS – link to above
- Suspicious H&N malignancies

PLEASE NOTE: All referrals received by Monash Health are triaged by clinicians to determine urgency of referral.

- Patients assessed as having an urgent need are offered an appointment within thirty days as assessed by the clinician.
- Patients assessed as having a non-urgent need for appointments in clinics where there is no waiting list, are offered an appointments within four months on a “treat in turn basis”.
- Patients assessed as having a non-urgent need for appointments in clinics that have a waiting list, referrers and patients will be notified of the expected wait times. Where the wait time does not meet patient needs, alternative service providers can be found by searching the Human Services Directory at http://humanservicesdirectory.vic.gov.au/Search.aspx

END OF GUIDE
**EAR:**

**Recurrent Acute Otitis Media**

**Patient Presentation**
- Recurrent ear infections associated with URTIs, otalgia, recurrent ear discharge

**Initial GP Work Up**
- MUST have recent audiogram (within preceding 6 months)

**Management Options For GP**

**Treat acute episodes:**
- Amoxicillin (45mg/kg) BD for 10 days OR
- Augmentin duo (45mg/kg) BD for 10 days
- Ciprofloxacin HC drops TDS for 3-7 days if otorrhoea

**Manage environmental factors:**
- Consider adjusting day care attendance (or to smaller day care facility)
- Discuss with parents risk of passive smoke and AOM (RR-1.66)
- Encourage weaning of pacifier after 11 months (RR-1.24)

**WHEN TO REFER**
- Recurrent ear infections with resulting social/developmental concerns
- Recurrent ear infections with associated otorrhoea
- Child with craniofacial abnormality
- Speech development delay
- Any adult with acute otitis media (need endoscopic examination of nasopharynx)

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**Middle ear effusion (glue ear)**

**Patient Presentation**
- Hearing loss, speech and language delay, balance and coordination problems

**Initial GP Work Up**
- MUST have recent audiogram (within preceding 6 months)

**Management Options For GP**

**May instigate intranasal steroids IF**
- child has associated nasal congestion/rhinorrhea and if over 2 years, and NO contraindications (e.g. mometasone 5mcg noxe) – no conclusive evidence of benefit

- Manage environmental factors (till definitive surgery)
- Encourage parents and teachers to speak clearly and directly to child
- Encourage parents to notify teacher so as to best position child in class

**WHEN TO REFER**
- Persistent audiological evidence of effusion longer than 3 months
- Audiological evidence of bilateral effusion with history suggestive of developmental delay in infant
- Audiological evidence of effusion with history suggestive of social/classroom impairment in school aged children
# Ear drum perforation

**Patient Presentation**
- Chronic or recurrent ear discharge, hearing loss

**Initial GP Work Up**
- Topical ear medication
- Keep ear dry
- Audiogram

**Management Options For GP**
- Review after 3 months

**WHEN TO REFER**
- Recurrent episodes of discharging ear, persistent discharge despite treatment, deteriorating hearing, when vertigo exists with acute perforation, persistent perforation after 3 months

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# Chronic ear disease

**Patient Presentation**
- Chronic ear discharge (for longer than 3 months)

**Initial GP Work Up**
- Audiogram

**Management Options For GP**
- Ciprofloxacin HC drops tds for 1 week
- Keep ear dry
- No irrigation of ear

**WHEN TO REFER**
- Discharging ear for longer than 3 months, failure to settle with topical medication, otalgia, headaches, vertigo, hearing loss
- Complications i.e. meningitis, facial palsy, vertigo

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# Tinnitus

**Patient Presentation**
- Chronic unilateral tinnitus

**Initial GP Work Up**
- Audiogram

**Management Options For GP**
- Refer to Australian Hearing Services for options eg: masking hearing aid

**WHEN TO REFER**
- Asymmetrical sensorineural deafness, vertigo

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# Vertigo

**Patient Presentation**
- Dizziness, instability, imbalance

**Initial GP Work Up**
- Audiogram
- Electrocardiogram ?cardiac factors

**Management Options For GP**
- Dix Hallpike manoeuvre to diagnose BPPV, and Epleys manoeuvre to treat if positive

**WHEN TO REFER**
- Intractable rotatory vertigo resistant to conservative measures. Unilateral hearing loss and tinnitus.
## Sudden hearing loss

**Patient Presentation**

Sudden sensorineural hearing loss (SSNHL): defined as sensorineural hearing loss of at least 30dB over three frequencies of less than three days duration.

**Initial GP Work Up**

- Audiogram

**Management Options For GP**

- If sensorineural hearing loss confirmed on audiogram (or suspected on tuning fork tests, if audiogram not available) and otological examination confirms normal tympanic membranes, oral steroids if not contraindicated at a dose of 1mg/kg for 7 days (immediate treatment)

### WHEN TO REFER

- All patients should be referred for proper workup including an MRI scan of the cerebellopontine angle.
**Patient Presentation**

- At least 2 of the following symptoms, one of which MUST be obstruction or discharge:
  - Nasal obstruction
  - Nasal discharge
  - Disturbance of smell and taste
  - Facial pain/ frontal headaches

**Initial GP Work Up**

- Establish disease entity: acute (ARS) – symptoms for <12 weeks (and recurrent with >3 episodes/yr) versus chronic (CRS) – persistent symptoms >12 weeks
- Initiate medical management
- Needs recent medical management sinomucosal disease (AFTER full course of medical Mx): may be normal in cases of recurrent ARS
- Manage co-existing allergies

**Management Options For GP**

- Treat any acute bacterial infection appropriately (10 day course of Augmentin duo forte)
- Medical management of CRS – 3 months of:
  - Oral roxithromycin 300mg daily
  - I/N saline rinse/irrigation (not spray) BD-TDS
  - I/N mometasone (BD for 2 weeks, then OD thereafter)
- 5 days only of BD oxymetazoline at start of course
- If symptoms persist after treatment – CT sinuses (no point in scanning before medical management)
- If rhinorrhea predominant symptom – add either Atrovent spray OR 2nd generation antihistamine
- Manage environmental factors:
  - Manage any co-existing allergies
  - Discuss contribution of smoking
  - Discuss role of environmental and household pollutants (wood/coal smoke, incense, perfumes, chlorine)

**WHEN TO REFER**

- Failed maximal medical management with CT evidence of sinus disease
- Complicated sinus disease (extrasinus extension, suggestion of fungal disease)
## Nasal congestion/obstruction

### Patient Presentation
- Blocked nose

### Initial GP Work Up
- If solely for obstruction – no workup necessary

### Management Options For GP

**Medical management with 2 month course of:**
- 5 days only of BD oxymetazoline at start of course
- I/N mometasone (BD for 2 weeks, then OD thereafter)
- BD-TDS saline rinse/irrigation (not spray)

**Management of environmental factors:**
- Manage any co-existing allergies
- Discuss contribution of smoking
- Discuss role of environmental and household pollutants (wood/coal smoke, incense, perfumes, chlorine)

### WHEN TO REFER
- Once failed adequate medical management
- Post traumatic where the patient has decided they want surgical management

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## Recurrent Epistaxis

### Patient Presentation
- Recurrent nose bleeds

### Initial GP Work Up
- Rule out any coagulation disorder
- Rule out any nasal masses or foreign body

### Management Options For GP

- Avoidance of precipitating factors such as nose picking
- Topical ointment BD for 1 week
- If bleeding heavy referral to emergency department may be necessary
- Cautery with silver nitrate

### WHEN TO REFER
- Once failed adequate medical management
### Nasal reconstruction / rhinoplasty

**Patient Presentation**
- Nasal obstruction with external nasal deformity

**Initial GP Work Up**
- If solely obstruction than no workup necessary

**Management Options For GP**

**Medical management with 2 month course of:**
- 5 days only of BD oxymetazoline at start of course
- I/N mometasone (BD for 2 weeks, then OD thereafter)
- BD-TDS saline rinse/irrigation (not spray)

**Management of environmental factors:**
- Manage any co-existing allergies
- Discuss contribution of smoking
- Discuss role of environmental and household pollutants (wood/coal smoke, incense, perfumes, chlorine)

### WHEN TO REFER
- Once failed adequate medical management
- Post traumatic where the patient has decided they want surgical management
## Throat - Recurrent Tonsillitis

<table>
<thead>
<tr>
<th>Patient Presentation</th>
<th>Initial GP Work Up</th>
<th>Management Options For GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent Tonsillitis</td>
<td>NA</td>
<td>Manage acute episodes with oral penicillin V (avoid amoxicillin/ampicillin)</td>
</tr>
</tbody>
</table>

### WHEN TO REFER
- When the frequency of attacks are causing significant educational/social constraints that all involved want to consider surgery
- Classic Paradise criteria (7 in past year, 5/yr over 2 years, or 3/yr for over 3 years)
- 2 prior episodes of quinsy in someone with no history of recurrent tonsillitis OR 1 quinsy if there is history

## Obstructive Sleep Apnoea - OSA (Paediatric)

<table>
<thead>
<tr>
<th>Patient Presentation</th>
<th>Initial GP Work Up</th>
<th>Management Options For GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnessed breath-holding/choking episodes during sleep</td>
<td>If snoring alone but not fitting above criteria of recurring episodes of infection – referral to respiratory unit for sleep study</td>
<td>Manage allergy/nasal congestion (nasal saline spray +/- intranasal steroids if not contraindicated)</td>
</tr>
<tr>
<td>Unrefreshing/restless sleep</td>
<td></td>
<td>Manage environmental factors</td>
</tr>
<tr>
<td>Behavioural/concentration issues as result</td>
<td></td>
<td>Discuss with parents risks of passive smoke exposure</td>
</tr>
</tbody>
</table>

### WHEN TO REFER
- Co-existing craniofacial abnormality
- Snoring with obvious obstructive features (apnoea/choking/breath-holding)
- Parents adamant they want surgical management and physical examination evidence of large tonsils (Brodsky scale)

## Obstructive Sleep Apnoea - OSA (Adult)

<table>
<thead>
<tr>
<th>Patient Presentation</th>
<th>Initial GP Work Up</th>
<th>Management Options For GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnessed breath-holding/choking episodes during sleep</td>
<td>Referral to sleep physician for evaluation, PSG and consideration of CPAP</td>
<td>Medically manage nasal obstruction:</td>
</tr>
<tr>
<td>Unrefreshing/restless sleep</td>
<td>Bariatric referral if BMI&gt;35</td>
<td>- Long-term intranasal steroids (mometasone) if no contraindications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Manage allergies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Weight loss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Manage environmental factors:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Discuss and manage basic sleep hygiene issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Discuss effects of smoking and alcohol intake</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Counsel regarding safety for work and driving while untreated</td>
</tr>
</tbody>
</table>

### WHEN TO REFER
- ONLY After respiratory assessment with polysomnography (PSG) and consideration/trial of CPAP
- If BMI greater than 30 – NEEDS to have adequately attempted weight loss programme (including review with bariatric surgeon if BMI>35) and been intolerant of maximal medical management
- If respiratory assessment finds predominant problem is nasal obstruction (irrespective of BMI)
**Dysphagia**

**Patient Presentation**
- Difficulty swallowing

**Initial GP Work Up**
- Barium swallow

**Management Options For GP**
- Referral may be required if there is suspicion of a sinister pathology in a patient with history of smoking and alcohol intake.

**WHEN TO REFER**
- Referral may be required if there is suspicion of a sinister pathology with history of weight loss.

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**Dysphonia**

**Patient Presentation**
- Hoarse voice

**Initial GP Work Up**
- Nil required

**Management Options For GP**
- Removal of irritants such as smoking, allergies, etc.
- Removal of voice abuse and advice regarding vocal hygiene.

**WHEN TO REFER**
- Persistent hoarseness in a smoker and history of excessive alcohol intake which fails to improve with conservative measures after 3 weeks.

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**Paediatric speech disturbance**

**Patient Presentation**
- Poor speech consistent with age of the child

**Initial GP Work Up**
- Audiogram
- Speech therapist assessment

**Management Options For GP**
- If audiogram normal, speech therapy input
- If audiogram abnormal manage otitis media with effusion as above

**WHEN TO REFER**
- If above measures fail to show any improvement in speech and suspicion of sensorineural hearing loss on audiogram.
**OTHER**

**Facial Palsy**

**Patient Presentation**
- Lower motor neurone facial palsy

**Initial GP Work Up**
- Examine ear and parotid region

**Management Options For GP**
- If Bell’s palsy suspected - treat immediately with oral steroids if not contraindicated (1mg/kg for 7 days). Note caution in elderly patient. Patient needs to be counselled regarding side effects. Oral anti-virals may also be used if suspicion of Ramsay-Hunt syndrome with vesicles in ear canal/on soft palate.

**WHEN TO REFER**
- Associated hearing loss or other suspected cranial nerve involvement. Failure of improvement in facial weakness after 3 weeks despite above measures

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**ENT HEAD & NECK ONCOLOGY**

**Possible Head & Neck Malignancies**

**Patient Presentation**
- Diagnosis, investigation and management of patients with malignancies of the head and neck, oral cavity, throat, nose and sinuses, salivary glands and thyroid.
- Certain benign conditions are also catered for, e.g. thyroid and salivary glands.
- Paediatric head and neck malignancy referrals are also accepted.

**Initial GP Work Up**
- None required if there is clinical concern of malignancy
- If a CT scan is done please include the chest.
- For neck lumps and thyroid an ultrasound +- CT scan.
- Other investigations will be tailored to the patient's condition.

**Management Options For GP**
- The clinic provides the latest and up to date multidisciplinary management of these conditions in a weekly multidisciplinary team meeting. Clinicians in attendance are from the specialties of ENT, Plastic Surgery, Oral and Maxillofacial Surgery, Dental, Radiotherapy, Palliative Care, Chemotherapy, Radiology, Pathology and Speech Pathology.

**WHEN TO REFER**
- Directly to the Head & Neck Clinical Nurse Specialist for all suspected malignancies - T: 9928 8711 or F: 9928 8052.
- Any airway compromise please contact the ENT registrar on call via T: 9594 6666.