ORL REFERRAL GUIDELINES -TARANAKI DHB & PHO's

In general, a higher level of priority will be given to patients in the following categories, if the relevant information is provided in the referral letter:

1. **Malignancy**: confirmed or high index of suspicion.
   eg hoarseness > 3 wks, neck/salivary gland lump, suspicious skin lesion
2. **Paediatric deafness**: children with obvious and disruptive heaving loss, or strong suspicion of hereditary hearing loss requiring rehabilitation
3. **Special/compelling circumstances**: eg high disease risk/deprivation status – social, socio-economic, ethnicity factors
4. **Infrequent or unusual conditions** (or special interest conditions)
   eg. unusual voice pathology, salivary gland lesions, preauricular sinuses
5. **Diagnostic conundrums**. *eg saliva leaking from ear, nasal polyps in children*

Problem	Actions	Local Implementation	Likely Priority
TONSILLITIS/ PHARYNX			
Acute Bacterial Tonsillitis	Penicillin for 7days (10 days if risk of rheumatic fever)	GP management	
Acute tonsillitis not responding to treatment after 48hours	• Throat swab • FBC, EBV serology	GP Management	
Acute tonsillitis (quinsy) or inf. mono unable to swallow or dehyd.	Consult specialist urgently	Phone ORL registrar or consultant	Urgent
Recurrent Tonsillitis >6 in the preceding 12 months, >5 per year in the preceding 2 yrs	Number of documented episodes & time period. Social impact/ time of work/school	Refer private or hospital OPD (with full documentation)	Semiurgent or Routine
Pharyngeal obstruction with snoring -**adult**	Snoring history Epworth Score (see below)	**E.S >12:** Refer ENT or physician **E S <12:** Consider referral private ENT, resp. physician or sleep clinic (NB. DHB funded sleep clinic –consultant access only)	Semiurgent Routine
Pharyngeal obstr/ snoring/ OSA -**children**	Snoring, sleep apnoea (observed), pharyngeal obstr, ?social circumstances *(Somnolence, failure to thrive, enuresis – refer **paediatrician**)*	**Refer ORL**: Clear parental history sleep apnoea: Clinical pharyngeal obstruction : Snoring only :	Urgent Semiurgent Routine
OTITIS MEDIA/ EXTERNA			
Recurrent acute otitis media (AOM) >6 episodes one year, 5 /year for 2 years; 4 /yr for 3 yrs	Trial prophylactic a/'biotic 3-6 mths Document discrete episodes AOM: (otalgia, short history, ear exam)	Failure low dose antibiotic **Refer ORL** (with full documentation)	Semiurgent or routine
Otitis media with effusion (OME) –bilateral disease present for >3 months	Symptoms – poor speech, school performance, social isolation Bilateral type B (flat) tymps Audiometry	**Refer ORL** with full documentation including functional impairment, time present, tymp/ audiometry result, social circumstance	Semiurgent or urgent
OME – unilateral - bilateral with no impairment	Tympanography. Audiology GP management & regular review	**Refer ORL** if unusual features or parental concern	Routine
OME -adult	• Unilateral in Maori, Hong Kong or South Chinese • With lymphadenopathy/ nasal obstr	With criteria: **refer ORL :** Without criteria: GP care or refer ORL :	Urgent or semiurgent Routine
Discharging ear/s (child /adult) -continuous or intermittent	Symptoms; Exam: TM not seen, central perforation, cholesteatoma or retraction pocket, social impact?	**Refer ORL** with full details symptoms, exam, Rx, social impairment If previous grommet ----	Semiurgent Urgent
Perforation – asymptomatic or occas. discharge (1x / yr), no social impairment	Local antibiotic for symptomatic episodes	GP management (Refer ORL if circumstances require repair) Refer ORL if symptomatic/complicated	Routine Semiurgent
Otitis externa – severe, pain, swollen shut	Analgesia, antibiotic (broad spectrum)	**Refer /phone ORL** urgently	Urgent
Otitis externa –chronic/ recurrent	Local drops, ear toilet	GP management or refer ORL	Routine

NASAL / SINUSITIS			
Nasal obstruction – polyps with functional impairment	Clinical polyp (not swollen turbinate) Trial intranasal steroid 3 months	Unilateral polyp –urgent **refer ORL** Bilateral polyps – **refer ORL**	Urgent Semiurgent
Nasal obstruction – functional impairment/ snoring	Exam –septum, turbinates Length of symptoms Trial of intranasal steroid 3 months	Functional impairment – **refer ORL** No impairment/ snoring only – consider ORL referral or sleep clinic	Semiurgent Routine
Sinusitis – recurrent 6 per year documented Failed trial medical Rx	History, no. of episodes, exam, smoking status Trial intranasal steroid/antihistamine	GP management Consider ORL referral	Routine
Rhinitis – chronic/ recurrent	Medical Rx –topical steroid, anti-histamines, ?short course oral steroid *Seasonal/perennial* -? Allergy testing	GP management Failure to respond – consider ORL referral	Routine
HEARING LOSS / Deafness			
Bilateral progressive	History – noise exposure; FH; Exam: tuning fork for sensorineural. Audiometry	Refer audiology (or ORL) Noise related – consider ACC	Routine
Unilateral/ asymmetrical	As above Sudden onset – refer urgently	Slow onset/ longstanding: **refer ORL** *Sudden onset*: refer urgent (day hours) -consider commencing steroids	Semiurgent Urgent
VERTIGO DIZZYNESS			
Recurrent true vertigo with severe social impairment (**not** dizziness/faintness)	History: no. of episodes, hearing loss?, medication history, treatment tried Audiometry	Refer ORL with symptom diary listing vertigo episodes & duration, hearing loss or change with episodes; audiometry report	Semiurgent or routine
HEAD & NECK ONCOLOGY			
Dysphagia, dysphonia/ hoarseness > 3 wk	History: time, PH, smoking/drinking, occupation; Exam: lymph nodes	New onset – refer urgent ENT Chronic problem -refer private or OPD	Urgent Semiurgent
Lump in neck or parotid with VII th n. palsy	Check for VII th nerve palsy	Refer urgent private or OPD If no VII th nerve palsy…….	Urgent Semiurgent
Globus sensation		GP management	Routine
Suspicious **skin lesions**	Check for nodes etc Consider excision or punch biopsy	Refer	Semiurgent or urgent
EPISTAXIS			
Recurrent/persisting **epistaxis**	Check for bleeding diathasis, hypertension. Consider cautery	Refer ORL if failed conservative Rx	Semiurgent/ urgent

NB: Patients below hospital OP access threshold (currently "routine" priority) can be referred to ORL consultants outside the hospital

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Epworth questionnaire (adapted from Johns MW Sleep 1991; 14(6), 540-5)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the appropriate number for each situation:

Situation	Chance of dozing			
	Never	Slight	Moderate	High
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (eg theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstance permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (without alcohol)	0	1	2	3
In a car; whilst stopped for a few minutes in traffic	0	1	2	3

TOTAL EPWORTH SCORE /24

(Guideline developed by Mr Waye Butt, Mr Nicholas Steventon, and theTDHB Guidelines Group. Approved Ver.2 Sept 2012