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Ear Nose Throat Lecture notes

SAMSONPLAB ACADEMY

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ENT

1. Presenting Complaints

1. Hoarse voice
2. Epistaxis (nose bleed)
3. Dysphagia (swallowing difficulty)
4. A feeling of a lump in the throat
5. Lump in the neck
6. Mouth or tongue ulcers

7. Stridor
8. Facial nerve palsy
9. Nasal obstruction
 10. Discharging ear
 11. Dizziness and vertigo
 12. Otalgia (ear ache)
 13. Hearing loss (deafness)
 14. Tinnitus=ringing in the ear
 15. Facial pain

2. Investigations in ENT

1. Pure tone Audiometry =this is the most commonly performed investigation in ENT. It is done to test for hearing loss.
2. Tympanometry=this is a way of measuring pressure in the middle ear. It used to find the cause of hearing loss, screen for glue ear (Acute Otitis Media) and checking for patency of grommet.
3. Dix-Hallpike manoeuvre is used to check for benign positional vertigo.
4. Caloric tests: they irrigate warm and cold water in each ear and they look for movement of the eyes. It used to check for the integrity of the brainstem-cerebellar pathways and central vestibule-ocular pathways.
5. CT scan is used to assess for the temporal bone and the inner ear, traumatic head injury, in suspected mastoiditis and assessment of mandibular involvement in mouth tumour.
6. MRI: To check for acoustic neuroma MRI is Gold standard, to assess the vascular structure in the neck and head and assessment of spread into cranial of sinonasal tumour
7. RAST (radioallergosorbent testing): to find the cause of allergy in a patient
8. Hearing tests or tuning fork test (use tuning fork 256 or 512 hz)

1. Rinne test

- $AC > BC$ = positive test = means normal or sensory neural deafness
- $BC > AC$ = negative test → conductive deafness
- Rinne positive on both sides and weber equal on both sides mean normal.
- Rinne positive on both sides but weber lateralizes to the other side mean sensory neural deafness on the opposite sides.
- Rinne negative on one side and weber lateralizes to the same side means conductive deafness on that side.

2. Weber test

- In the middle → normal (or equal on both sides)
- Localizes to affected ear ⇒ conductive deafness on that side
- Lateralizes to one side means sensory neural deafness on the opposite side.

NB: Rinne's test suggests and weber's test confirms.

Neonatal hearing screening test: 2 tests are used in the UK to screen all the neonates.

- 1) Automated oto-acoustic emissions (AOAE) and
- 2) Automated auditory brainstem response (AABR).

These tests are done between day 10 and 14. For babies who did not require special care usually uses Automated oto-acoustic emissions. Babies not passing this test are given the

AABR. And if the test is not passed then the baby is referred for audiological assessment.

Pneumonic: CSSO: Conductive deafness same side, Sensory neural Opposite side. (Which means for conductive deafness Weber's goes on the same side and for sensory neural Weber's goes on the opposite).

3. Infection of the Pinna

Localised infection of the pinna treat with antibiotics such as co-amoxiclav but if there is cellulitis treat with cefuroxime and metronidazole

4. Otitis Externa

This is a common infection in ENT. There is discharge, redness and swelling of the ear but the tympanic membrane is normal.

Risk factors: Swimming, Diabetics and Psoriasis). History of travel abroad for a holiday where possibly patient was swimming. If there is history of travel for a holiday it means there is chance that he could have been swimming in the rivers

Investigation: swab of discharge

Treatment: Gentamicin eardrops and hydrocortisone drops. If you have an option with only Gentamicin drops you can also choose it.

5. Acute Otitis media

This is a very common condition. Almost everyone will suffer with acute otitis media during their lifetime. Signs and symptoms may include a preceding URTI, severe and progressive otalgia, or a discharge this is usually associated with a resolution of the otalgia.

A diagnosis is made by taking a history, examining the tympanic membrane (which is red), and taking the patient's temperature.

In viral acute otitis media the tympanic membrane is pink. In this case antibiotics are not needed just give analgesia.

Treatment for acute otitis media is controversial. Systematic review suggests treatment with analgesia only. However, these reviews may have included a high proportion of viral ear infections where antibiotics would not be expected to be useful.

Management

- 1) Give analgesia in all cases.
- 2) Give oral antibiotics for one week such as co-amoxiclav PO or simply amoxicillin.
- 3) Warn the patient that the discharge may continue for 1 week
- 4) When the infection has resolved always check that the tympanic membrane has returned to normal.
- 5) If viral give analgesia.

Recurrent infections of the middle ear

These must be differentiated from one persisting infection. Treat any acute infections actively as above.

If the patient has more than 5 infections in 6 months, then consider alternative treatment such as grommet insertion or a prolonged course of antibiotics.

Treatment

Medical – consider prophylaxis with Trimethoprim (TMP) / Sulfamethoxazole (SMX) syrup – 2mg/kg TMP and 10mg/kg SMX as a single nightly dose PO for 3 months.

Surgical – if there is an effusion or glue ear has been present for longer than 3 months consider grommet insertion especially if there is effusion. AOM + Effusion = Glue Ears and the treatment is grommet.

All treatment needs monitoring – use an infection diary to record episodes of infection pre- and post-treatment.

Caution

Acute otitis media is often misdiagnosed. Children with nocturnal earache often have glue ear/ Eustachian tube dysfunction. The tympanic membrane may be red or infected but there is no discharge and the pain resolves very quickly upon walking.

Complications of Acute Otitis Media**1. Chronic infection**

An infection may persist and become chronic. This may be due to resistant bacteria. Use a broad-spectrum antibiotic such as ciprofloxacin.

Consider myringotomy (making small hole in the TM) for the relief of symptoms or to obtain microbiological information.

2. Facial nerve palsy (7th Nerve palsy)

10% of people have a dehiscence facial nerve. This may result in a facial nerve Palsy - when the bone covering is absent over the nerve. This may result in a facial nerve irritation and palsy secondary to the middle ear inflammation.

The patient must be admitted to hospital and given IV antibiotics, e.g. Cefuroxime. Also consider steroid therapy, Prednisolone 1mg/kg per day, if there is total facial paralysis, to be continued for a week.

Consider Myringotomy and grommet insertion if the condition fails in 24 hours.

3. Acute Mastoiditis

This is an infection of the mastoid air cells, which will lead to a severe earache with tenderness, swelling and redness behind the pinna. The pinna also be pushed forwards (displaced) making it look more prominent.

Investigation: CT scan

Treatment: Admit and Intravenous antibiotics (Co- amoxiclav)

4. Chronic perforation of the tympanic membrane

Repeated infections, which perforate the tympanic membrane, can lead to chronic perforation. Usually there is ear, which is followed by purulent discharge, and then the pain disappears.

Discharge = Resolving Earache

5. Sensorineural hearing loss (SNHL)

Rarely, toxins can spread to the inner ear (vestibulocochlear nerve) to produce a sensorineural hearing loss (vestibulocochlear nerve)

6. Vertigo

Infection near the lateral semicircular canal can produce a para –labyrinthitis. This can cause a spectrum of vestibular disturbance ranging from mild unsteadiness to disabling vertigo.

7. Glue ear/otitis media with effusion-this is common in children.

Glue ear is caused by a combination of exposure to infection and a non-functioning Eustachian tube. Almost 8 out of 10 children will have glue ear at some time during childhood. The incidence of glue ear decreases with age as the immune system develops and the Eustachian tube function improves.

The signs and symptoms of glue ear can include: decreased hearing, recurrent ear infection, poor speech development, failing performance at school and sometimes, antisocial behaviour. It causes conductive hearing loss.

Risk factors

- 1) Smoking parents
- 2) Bottle feeding

- 3) Day-care nursery
- 4) Cleft palate
- 5) Atopy (eczema, asthma, hay fever)
- 6) Down syndrome

Investigations

- 1) Full history and examination (including the palate)
- 2) Age appropriate audiometry (conductive hearing loss) and tympanometry (to check pressure).

Management

- 1) Hearing disability – how the child is coping with their hearing problem socially and at school is more important than the actual level of hearing loss.
- 2) Appearance of tympanic membranes – if there is gross retraction, intervention may be needed to avoid retraction pocket formation.
- 3) Grommet (tympano Tube)

Treatment

There are three options:

- 1) Watchful waiting- this should apply to all patients for 3 months as glue ear will resolve in 50 % of cases.
- 2) Hearing aid – there is a window of opportunity at 4-8 years of age. It is non-invasive, but may lead to teasing at school
- 3) Insertion of grommets

8. Chronic suppurative otitis media without cholesteatoma

This common condition is associated with Eustachian tube dysfunction with or without an infection in the mastoid.

As with other ear disease, its prevalence continues despite antibiotics.

The signs and symptoms of chronic suppurative otitis media may include persistent recurrent otorrhoea, perforation in the tympanic membrane (usually central), and no cholesteatoma present.

Risk factors

- 1) Smoking patient
- 2) Smoking parents
- 3) Acute otitis media
- 4) Decreased immunity

Investigation

- 1) Full history and ENT examination
- 2) Microscopy of the eardrum with aural toilet (washing)
- 3) Swab for microbiology

Management

- 1) Give appropriate topical and system antibiotics based on the swab result. The condition may settle with antibiotics and water precautions.
- 2) Perform regular cleaning of the ear using microsuction –aural toilet.
- 3) Persistent infections may need surgery

4) Myringoplasty-repair of the perforated tympanic membrane.

5) Cortical mastoidectomy (debridement)

9. Chronic suppurative otitis media with cholesteatoma

This is often divided into congenital and acquired forms of the condition:

Congenital cholesteatoma results from an abnormal focus of squamous epithelium in the middle ear space, i.e. a dermoid.

Acquired cholesteatoma most often results from chronic Eustachian tube dysfunction.

It was hoped that the incidence of this condition would have changed with the advent of antibiotics. Unfortunately, the disease continues and can present at any age. Signs and symptoms may include recurrent otitis media with a mucopurulent discharge, hearing loss, facial nerve palsy, and vertigo.

Development of a cholesteatoma

Initially squamous epithelium migrates out of the sac with ease, but as it enlarges the squamous epithelium builds up and can no longer escape. If infection supervenes on the impacted squamous epithelium/keratin, then lytic enzymes are released causing destruction of local structures. It is normally in the attic of the ear.

Investigation:

CT scan of the temporal bone to look for pneumatisation of mastoid or erosion of scutum.

Management: usually surgical treatment

6. HEARING LOSS=DEAFNESS

The aetiology of hearing loss can be determined by careful consideration of the patient's history, a clinical examination, and the findings of special investigations.

The age of onset of the patient's hearing loss is important, as is any family history of hearing loss.

Classification of patients presenting with hearing loss

Acquired	Congenital
1. Prebycusis	Syndromic
2. Noise-included hearing loss	Non-syndromic
3. Idiopathic sudden hearing loss	
4. Autoimmune hearing loss	
5. Vascular causes	
6. Ototoxicity	
7. Non-organic hearing loss	
8. Otosclerosis	

1. Otosclerosis

Here new bone is *formed around the stapes footplates*, which leads to its fixation and consequent *conductive hearing loss*.

This condition is usually common in pregnancy.

It manifests as slowly *progressive hearing loss*, usually beginning in the patient's twenties. There is usually a family history of the condition. It is bilateral, common in pregnancy

The patient may have difficulty hearing when chewing and may have problems with quiet conversation. Some 69-80% of patients have tinnitus.

Accelerated progression is often seen during pregnancy.

Bilateral conductive hearing loss. It usually begins in the twenties.

Incidence

- The female to male ratio is 2:1
- Temporal bones have evidence of otosclerosis.
- The population have a clinical manifestation of the disease.
- The condition is bilateral in 70% of patients.
- 50% of patients with otosclerosis have a family history.

Investigations

- Check for a normal mobile intact tympanic membrane.
- Consider a CT scans – this may help to exclude other bony abnormalities of the middle ear causing ossicular fixation.

Differential diagnosis

Paget's disease - this is the only other bony lesion which involves the middle ear. Here there is increased alkaline phosphatase and a mixed hearing loss (conductive or sensory neural sensory loss)

Osteogenesis imperfecta – (also known as Van der Hoeve syndrome) leads to mixed hearing loss with **blue sclera**. There is frequently a history of multiple bony fractures with no history of trauma.

Treatment

The options are:

- No treatment
- Hearing aid as an initial treatment.
- Surgery- stapedectomy after a 3-month trial of hearing aid

2. Presbycusis

This term describes a decreased peripheral auditory sensitivity. It is usually age-related, and affects men more than women.

Usually starts at the age of 40.

Signs and symptoms

This condition shows itself as bilateral, progressive, symmetrical sensorineural hearing loss, with no history of noise exposure. Decreasing central auditory discrimination leads to phonemic regression.

Investigations

- 1) Otoscopy
- 2) Pure tone audiogram

Management

The patient may be given counselling and advice about hearing loss, and given a hearing aid where the symptoms are troublesome

3. Noise-induced hearing loss

This is defined as damage to the inner ear caused by exposure to loud noise. There is a relationship between the volume of sound and its duration, which causes damage.

Signs and symptoms

The patient will usually present with bilateral and symmetrical hearing loss.

There may be a noise-induced temporary threshold shift (TTS) – for example. Hearing may improve over the weekend if the problem is noise at work.

The patient may have difficulty hearing in background noise or they may have tinnitus.

Bilateral sensory hearing loss (SNHL)

Investigation

- Audiometry

Treatment: Hearing aid

Prophylaxis: ear defenders

4. RIFFLE SHOOTING

This usually results in unilateral sensory neural loss, depending on how a person is holding the gun

NB: Acoustic trauma's when sudden very loud noise causes perforation of the eardrum. Sometimes someone can experience if slapped on the ear strongly. There is usually bleeding from the ear.

5. OTOTOXICITY = Drug induced especially by Gentamicin.

Caused by medication such as gentamicin which an aminoglycoside

6. Autoimmune associated with SLE, RA

7. Idiopathic hearing loss where there is no cause found.

8. AUTOIMMUNE causes like SLE or RA

9. SYNDROMIC HEARING LOSS

I. Goldenhar syndrome

Either conductive hearing loss or sensory neural hearing loss

Associated with skeletal abnormalities like cervical spine or skull.

Usually a child

Associated with mental retardation or cleft lip or palate

II. Alport syndrome

Sensory neural hearing loss associated with glomerulonephritis

It is progressive in nature. It presents with renal symptoms and hearing loss

Family history of Haematuria (Glomerulonephritis) and hearing loss

NB: syndromic hearing loss is associated with other abnormalities.

10. NON-SYNDROMIC HEARING LOSS

This is when a patient is complaining of hearing loss but actually he/she has no hearing loss or when a patient exaggerate the hearing loss

11. Barotrauma=acoustic trauma: Especially when on flight can lead to perforation of the tympanic membrane. This will cause conductive deafness.

12. Acoustic neuroma=tumour of the 8th nerve also called schwannoma.

13. Acute otitis media with effusion will cause conductive hearing loss.

7. VERTIGO

Peripheral

1. Meniere's disease
2. Benign paroxysmal positional vertigo (BPPV)
3. Vestibular neuritis (labyrinthitis)

4. Vertebrobasilar insufficiency (atherosclerosis)

Drugs due to ototoxicity

1. Gentamicin due to ototoxicity.
2. Diuretics due to postural hypotension
3. Cotrimoxazole
4. Metronidazole

Peripheral vertigo usually has severe vertigo + nausea, vomiting + hearing loss + tinnitus + nystagmus (horizontal)

While in central vertigo, hearing loss and tinnitus are less common

1. Benign positioned vertigo: Sudden onset of dizziness lasting > 30 sec. Exacerbated by head movement especially when turning in bed.

Investigation: Dix-Hallpike manoeuvre

Px 1. Self-limiting within months

1. Counselling and reassurance
2. Alcohol
3. Betahistine, prochlorperazine
4. Main treatment is manoeuvre called Epley manoeuvre

2. Meniers disease: (DVT) deafness, vertigo and tinnitus

Also nausea and vomiting, usually recurrent episodes. Intermittent symptoms and deafness resolves but dizziness persists

The main thing is that symptoms occur in episodes.

Treatment: 1. Cyclizine,

2. Prochlorperazine (phenothiazines work by blocking dopamine)
3. Operative decompression of saccus endolymphaticus

3. vestibular neurectomy/ labyrinthectomy if persistent.

Prophylaxis: betahistamine.

8. VESTIBULAR NEURITIS OR LYMBICITIS: - Symptoms usually come after viral URTI

Sudden vertigo

Vomiting

The main feature is onset of symptoms after viral illness.

Treatment: cyclizine, improvement occurs in days, full recovery occurs within 2-3 weeks

9. Acoustic Neuroma or vestibular schwannoma: Originates from schwann cell. It is the tumour of the 8th Nerve. It is usually located at the cerebellopontine angle

Vestibular schwannoma test S.N- deafness by compressing cochlear N

- Ipsilateral cerebellar signs
- signs of raised intracranial pressure

- Dizziness
- Affect other CN 5,6,7,9,10 facial pain or numbness
- Usually there is family history.

Invx : MRI

Treatment: surgery

10. CHRONIC NASAL OBSTRUCTION

Child

1. Large adenoids
2. Rhinitis
3. Postnasal space tumour
4. Foreign body

□

Adult:

1. Deflected nasal septum
2. Rhinitis (allergic vasomotor)
3. Polyps
4. Sinusitis
5. Granuloma (TB, sphyllis)
6. Topical vasoconstrictor
 1. Vasomotor rhinitis: 1. Bilateral nasal obst.
 2. Rhinorrhoea
 3. swollen oedematous turbinate's

TREATMENT:

No definite

Ipratropium nasal spray for Rhinorrhea

Cautery or surgery to reduce ^ info turbinate

-

2. Allergic Rhinitis: 1. May be seasonal (hay fever) or continuous
 2. Exposure to allergens like pollens, house dusting
 3. Sneezing, pruritis, Rhinorrhoea
 4. swollen turbinate's

Px

1. Desensitizing injury
2. Antihistamine
3. Systematic decongestants

Epistaxis: This is bleeding from the nose the cause is unknown 80%
common in elderly and the commonest cause is hypertension(always check BP)

- More in winter
- After trauma (nose picking)
- Blood dyscaryosis , alcohol

Mx. Anterior Epistaxis little's area

1. Sitting position, the head downward
2. Apply pressure for 10-15 minutes on soft part of the nose
3. Insert ribbon gauze with xylometazoline and lidocaine
4. Cautery with silver nitrate sticks
5. If persists => anterior packing with Vaseline
6. If persistent do posterior packing

Posterior Epistaxis

1. If bleeding site is seen → bipolar cautery
2. If cannot be seen → posterior packing
3. If still bleeding → examination under GA + diathermy on ligation of sphenopalatine art.

Sinusitis: 1. Fever, facial pain on sinuses which is worse when you bend forward.

4. Nasal discharge, posterior. Nasal drip
5. Nasal obstruction
6. Anosmia

Causes: - bacterial to viral

- Swimming in infected water
- Septal deviation, polyps (predisposing factors)
- Immunodeficiency

Investigation: CT scan + rigid endoscopy

Treatment: Acute: Bed rest, decongestant, analgesia amoxiclav, if no response → drainage with lavage(washout)

STRIDOR

1. Laryngomalacia
2. Laryngitis
3. Epiglottitis
4. Laryngo-tracheo-bronchitis
5. Anaphylaxis
6. Haemangioma, papillomas
7. Trauma (thermal / chemical), intubation

Laryngomalacia

1. Present hours after birth
2. Stridor most noticeable in certain position e.g during sleep or when child is excited;
3. Symptoms are worse when child is in lying position and symptoms improve when child is sat up.

Treatment : no treatment need, spontaneous resolution within 2 years is usually the course of the disease.

Epiglottitis:

1. Toxic child (child is ill with high fever and drooling of saliva)
2. Acute onset
3. Febrile, drooling of saliva
4. Sitting position

5. Voice muffled
6. Continuous stridor
7. The causative organism is Haemophilus influenza)

Rx- do not examine throat, call anaesthetist to intubate the child.

- Laryngoscopy to see cherry red swollen epiglottis
- Blood culture
- Cefotaxime

Croup: - This is the same as laryngobronchiolitis, it is commoner than epiglottitis

- Viral cause (parainfluenza)
- Slow onset
- Barking cough
- No drooling of saliva (unlike epiglottitis)
- Stridor only when child is upset

In severe case => cyanosis

Treatment: 1. Steroid: dexamethasone oral or budesonide 2. Nebulised adrenaline. 3. Humidified oxygen.

HOARSENESS OF VOICE

ACUTE

1. Laryngitis this is upper respiratory tract infection (fever, running nose, sneezing or simply called coryza symptoms)
2. CA larynx (in smokers, elderly patient, weight loss, anaemia, anorexia)
3. Trauma (especially after prolonged intubation)
4. Singing=singer's nodes
5. Shouting=voice abuse (e.g. people after a football match)
6. Laryngeal abscess

CHRONIC

1. Laryngitis
2. Vocal cord paralysis due to recurrent laryngeal N. Palsy
3. Functional disorders
4. Laryngeal carcinoma.

11. ENT TUMOURS:

1. SINONASAL MALIGNANCY

This is a group of malignancy affecting the nose and the sinus system

Squamous cell carcinoma accounts for 70% of all sinonasal tumours

Nickel workers are predisposed to SCC (squamous cell carcinoma)

Wood workers like carpenters are predisposed to adenocarcinoma

Adenocarcinoma accounts for 10% of all tumours

LOCATION OF TUMOURS

1. Maxillary
2. Nasal
3. Ethmoid bone

Symptoms:

Nasal obstruction

Sinusitis

Maxillary symptoms (loose teeth, painful ulcers on the palate, cheek swelling)

Ethmoid bone symptoms (diplopia, nasal obstruction, headache)

2. NASOPHARYNGEAL CARCINOMA

Symptoms:

Epistaxis

Nasal obstruction

Headache

Middle ear effusion

NB: everyone presenting with unilateral middle ear effusion must have postnasal space visualisation to exclude tumour

Rx: radiotherapy and surgery

3. TONSILLAR TUMOUR

1. The commonest is Squamous Cell Carcinoma (SCC)

Common in elderly and middle aged

Pain in the throat, otalgia, ulcer on the tonsils, lump in the cheek

Investigation: FNAC (biopsy)

Rx: surgery with/without radiotherapy

4. LYPHOMA

Second commonest tumour

Enlarged tonsils

Lymphadenopathy

-Usually there is no mucosa ulceration. (no ulcer on the tonsils)

Inx: FNAC (biopsy)

Treatment: Radiotherapy

12. OBSTRUCTIVE SLEEP APNOEA

This is usually in obese people. They snore a lot during the night and feel tired most of the time during the day. Also they are sleepy during the day. They are usually hypoxic during the night. They wake up very frequently during the night. This condition is also associated with hypertension

Investigation: Polysomnography or pulse oxymetry during sleep.

13. COMMON OPERATIONS IN ENT SURGERY**1. TONSILLECTOMY****INDICATIONS**

1. Recurrent acute tonsillitis
2. Chronic tonsillitis
3. Obstructive sleep apnoea
4. Oral pharyngeal obstruction

COMPLICATION:

Haemorrhage (if between 5-12 days its like infection the cause-this is called secondary haemorrhage).

Treat it with antibiotics.

Bleeding within 24hrs is called primary haemorrhage (usually its due to bleeding from the operation site)

2. ADENOIDECTOMY

INDICATION is adenoids causing obstructive sleep apnoea or adenoid causing glue ear.

This condition is usually in children because in adults the tonsils and adenoid they regress.

3.GROMMET INSERTION: Usually done for glue ear

4. **ANTRAL WASHOUT:** Acute sinusitis not responding to antibiotics in order to obtain microbiology sample

14. FACIAL NERVE PALSY OR 7TH NERVE PALSY**CAUSES**

1. **BELL PALSY:** Idiopathic cause of 7 nerve palsy. Excluding other causes makes diagnosis. The commonest cause is a virus.

Rx: Prednisolone or simply steroid. Usually there is good recovery within 2 weeks

Refer to ophthalmologist due to risk of exposure Keratitis

2. RAMSAY HUNT SYNDROME

7 nerve palsy due to herpes zoster

Vesicles in the ear

Usually in immunocompromised e.g. diabetes, on steroid, HIV, elderly or cancer.

Treatment: Acyclovir oral but if patient immunocompromised then intravenous.

14. TONSILLITIS:

Infection of the tonsils

Common causes include B-haemolytic streptococcus, pneumococcal, viral. Symptoms: sore throat, fever, enlarged tonsils, white pus or exudates on the throat it means the cause is bacterial and you must treat with antibiotics.

Treatment: penicillin V. If patient not able to swallow then admit for intravenous antibiotics

Avoid Ampicillin or amoxicillin due to risk of infectious mononucleosis (EBV). If a patient is treated with amoxicillin and the cause was EBV patient may develop rash all over the body.

GLANDULAR FEVER =ALSO CALLED INFECTIOUS MONONUCLEOSIS

Caused by EBV

Symptoms are sore throat with Coryza symptoms

Investigation: monospot or Paul bunnell blood test

Treatment: analgesia, if you give amoxicillin patient will develop rash all over the body.

COMPLICATIONS OF TONSILLITIS:

1. Airway obstruction.

2. Quinsy: peri-tonsillar abscess. There swelling of the soft palate and the uvula is displaced to one side, drooling of saliva and trismus (failure to open the mouth)

Treatment: Incision and drainage

3. Parapharyngeal abscess

Diffuse swelling of the neck

Admit and do incision and drainage.

15. FOREIGN BODIES (FB) IN ENT

FB IN THE EAR

Symptoms include: pain in the ear, deafness, or no symptoms.

Management:

Children need it removed under general anaesthesia

Insect use olive oil

Soft foreign body e.g. cotton wool use crocodile or Tilley's forceps

Solid FB such as a bead uses a wax hook or probes or sometimes suction. DO NOT USE FORCEPS

Refer to ENT if failed attempt or uncooperative child or suspected trauma.

FB IN THE NOSE

Unilateral purulent foul smelling discharge

Nasal obstruction

Epistaxis

Usually in a child

Management:

Ask child to blow the nose

Solid FB like a bead uses a wax hook or probe

Avoid using a pair of forceps as you may push the object forward

Soft FB e.g. cotton wool use crocodile forceps or Tilley's forceps.

FB IN THE THROAT

ACUTE ONSET OF SYMPTOMS

Pricking sensation in the throat

Dysphagia

Pain in the throat

Management: use anaesthetic spray

X-ray of the neck

Use Tilley' forceps

Refer to endoscope if failed attempt, airway obstruction (urgently) or of good history but can not see FB or if visible FB on X-ray

FB OESOPHAGUS

IMMEDIATE ONSET OF SYMPTOMS

Early presentation

Retrosternal pain

Drooling of saliva

Pain

Management: X-ray neck and chest

Endoscope to remove under GA but if GB below oesophagus expectant management that the FB will pass with stool. Warn patient to come back if FB not passed in 48hrs or sign of intestinal obstruction.

NB: sharp objects needs to be removed regardless of the position.

NB: sharp objects need to be removed endoscopically as they can cause a cut to the intestines and lead to peritonitis

16. TRAUMA IN ENT

FRACTURED NOSE=clinical diagnosis, X-ray not required, refer to ENT for follow if there is a lot of swelling which is making examination difficulty.

BASAK SKUL FRACTURE: Rhinorrhoea or otorrhoea or raccoon eye or battle sign (this is bruises on the mastoid bone)

BONES FRACTURED ARE: ETHIMOID BONE (rhinorrhoea or trauma to the forehead) AND TEMPORAL BONE (otorrhoea or fracture to the mastoid)

Raccoon eyes =bruises around the eye.

Battle sign =mastoid bruising.

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