HPH Guidelines for Adult Otolaryngology Referral

Effective February 27, 2017

This document is designed to help the primary care physicians determine when to refer patients for outpatient ENT consultation. They should only be used as a tool and not as exclusive indicators for referral.

1. **Cerumen impaction:**
    a. Trial of Debrox for 4 days and irrigation by PCP.
        i. *Avoid irrigation if patient has history of TM perforation or PE tubes.
    b. Refer to ENT if there's hearing loss, otorrhea, pain, history of ear surgery (including tubes), or not resolving with topical antibiotic ear drops.

2. **Tinnitus**
    a. Bilateral ear ringing without other symptoms likely requires reassurance only. Encourage patient to mask with broad band white noise.
    b. If patient has any other ear symptoms (hearing loss, vertigo, otalgia, drainage) refer to ENT.
    c. If unilateral tinnitus refer to ENT.
    d. **Hearing Loss/Tinnitus:**
        i. Referral to ENT with a pre-clinic audiogram.

3. **Epistaxis**
    a. If not active, trial of nasal saline spray, lubricant such as Nasogel or Vaseline.
    b. Reverse any anticoagulation if appropriate.
    c. Active bleeding referred to ENT or ER.

4. **Sore throat**
    a. If persistent sore throat for more than 2 weeks, refer to ENT.
    b. If persistent lymphadenopathy, hemoptysis, dysphagia or hoarseness refer to ENT.

5. **Sinusitis**
    a. Uncomplicated acute sinusitis does not require referral to ENT unless atypical symptoms or red flags (facial or orbital cellulitis or neurologic symptoms).
    b. Chronic Sinusitis: 12+ weeks of purulent drainage, nasal congestion, facial pressure, or decreased sense of smell:
        i. Antibiotic therapy for 3 weeks and/or failed nasal corticosteroid use x1 month → refer ENT

6. **Dizziness**
    a. Establish if patient has dizziness or vertigo.

i. Vertigo = room spinning lasting minutes to hours to days, very likely an ENT problem.
ii. Dizziness = lightheadedness, feeling off balance, woozy, gait instability, less likely an ENT problem. Consider other causes of symptoms such as circulatory, metabolic, or neurologic disorders (including diabetic neuropathy).

b. If patient reports dizziness with changing body position (sitting to standing), obtain orthostatics, especially if cardiovascular comorbidities.
c. If history of migraine, concussion, or head trauma, refer to neurology first to rule out central or neurologic etiology.
d. If concurrent hearing loss, tinnitus, otalgia, or aural fullness, refer to ENT.
e. Recommend NOT prescribing meclizine (Antivert) for the dizzy patient. Low dose Valium 1-2 mg PO Q8H PRN can be more effective.

7. Ear pain

a. If normal ear exam without subjective hearing loss, palpate temporomandibular joint and muscles of mastication to assess for TMJ dysfunction and/or Myofascial Pain Dysfunction, a common source of ear pain—especially bilateral otalgia.
b. Consider referral for TMJ dysfunction to Hawaii TMJ Institute.

8. Chronic Otitis Media/Recurrent Acute Otitis Media

a. 3 month observation period → Formal audiogram if no improvement → refer to ENT.

9. Nasal obstruction/Nasal allergies

a. 1 month nasal corticosteroid emphasizing DAILY use → allergy panel (immunoCap RAST) if no response → refer ENT.

10. Obstructive Sleep Apnea

a. Adults: polysomnogram → CPAP trial as initial therapy if abnormal PSG (AHI>5) → refer if failing CPAP.
b. Peds: offer polysomnogram if parents want proof of apnea before considering surgery → refer to ENT if sleep study is abnormal (AHI>1).

11. Hoarseness

a. Lasting longer than 3 weeks → refer to ENT.