Primary Care Referral Guidelines – ENT

IMMEDIATE REFERRAL TO THE EMERGENCY DEPARTMENT

Please discuss all emergency referrals with our ENT Admitting Officer or urgent referrals with the ENT Registrar - call switchboard 9929 8666

- Sudden sensorineural hearing loss
- ENT conditions with associated neurological signs
- Quinsy
- Post tonsillectomy haemorrhage
- Foreign bodies
- Isolated neurological signs – refer to any Emergency Department
- For other indications for referral, please see below

ENT Conditions Not Accepted

The following are not routinely seen at the Royal Victorian Eye and Ear Hospital and may be appropriately managed by the GP until they reach the clinical thresholds identified in these Referral Guidelines. Suggestions are made for primary care management, and patients should only be referred if these approaches have been unsuccessful.

• Allergy Rhinitis	
• Tonsillitis	
• Infectious Mononucleosis	Unless complication associated
• Acute Sinusitis	Unless complication associated
• Otitis Externa	
• BPPV	Unless failed Epley manoeuvre after 3 treatments or Epley Omniax assessment/ treatment is required (refer to page 9 below)
• Postural hypotension	
• Age related hearing Loss	
• Noise induced hearing loss	
• Tinnitus	Without hearing test result
• Sleep apnoea/disturbed sleep in children	Unless obstructive tonsils and adenoids
• Prescription of Hearing Aids	Refer to the Hearing Aid Primary Care Management Guideline

The Hospital aims to provide tertiary services for patients with Otolaryngology, Head and Neck Surgical conditions in an appropriate time frame (refer page 3 for clinic timeframe categories). Referrals will not be accepted where a condition is identified from the patient's referral details as requiring primary care, or as being suitable for ENT or allied health assessment/management in the Community.

Currently the hospital has an excessive wait list for Category 3 patients. Referral of such patients may not be accepted and it is suggested that referral for initial assessment by local ENT specialist is arranged.

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1. Clinic Timeframe Categories

The following table gives an indication of the timeframe within which patients of different acuity are expected to be seen.

Category	Definition
Emergency	A patient whose condition is identified from referral details as having an acute hearing or life threatening condition where immediate medical or surgical intervention is required *Discuss with the Admitting Officer in the Emergency Department – call switch on 9929 8666 – to confirm immediate referral to the Emergency Department*
Urgent: (within 2 weeks) Waiting list: Category 1	A patient whose condition is identified from referral details as having the potential to deteriorate quickly to the point that it may become an emergency
Soon(semi-urgent): (2-6 weeks) Waiting list: Category 2	A patient whose condition is identified from referral details as causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency
Routine: (next available) Waiting list: Category 3	Patients whose condition is identified from referral details as being unlikely to deteriorate quickly and does not have the potential to become an emergency
Primary Care - not accepted	Patients whose condition is identified from referral details as requiring primary care, and not reaching the threshold criteria for the hospital's specialist services. Refer to the Primary Care Management Guidelines.

2. Referral Resources

In order to triage accurately to the most appropriate specialist clinic, within a clinically suitable timeframe, it is critical that we receive accurate and detailed referral information.

The referring GP must include:

- Clear statement of symptoms
- Duration of problem
- Functional impact
- Risk factors
- Date of last audiology assessment – include report
- Current diagnostic report if indicated in the referral guidelines

These guidelines are not designed to assist with a definitive diagnosis, but rather to identify key clinical thresholds requiring referral to the Royal Victorian Eye and Ear Hospital for specialist diagnosis.

If the GP is unable to ascertain the clinical information required to identify the thresholds, this may be obtained from an Audiologist or Vestibular Physiotherapist in some circumstances. To assist the GP a form letter, Request for Diagnostic Support, is available that details the information required for the patient to be triaged appropriately at the hospital. This can be funded through Medicare with a GP referral.

Local ENT specialists, audiologists and physiotherapists can be located at the Human Services Department's HSD - Search website.

(Type in 'Suburb/Town or Postcode' > Select the 'Practitioner' tab > Select ENT or Audiologist in 'Speciality' > Select 'Site search' for clinics or 'Practitioner Search' for specific people).

Audiologists can also be located through http://www.audiology.asn.au/pdf/service/asa-vic.pdf

Vestibular Physiotherapists can also be located by following this link.

3. Referral Guidelines

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
DIAGNOSES		
Head and Neck		
Infection mononucleosis		Top
Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Odynophagia • Fatigue Examination: • May mimic bacterial tonsillitis • Cervical lymphadenopathy • Membranous tonsillitis	• Supportive care • FBE, Monospot	• Noisy breathing/breathing difficulty/voice change/severe odynophagia – refer immediately to ED
Lower Motor Neuron Facial palsy		Top
Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Weakness or paralysis of movement of all (or some) of the face Examination: • Weakness or paralysis of movement of all (or some) of the face • No sparing of forehead muscle weakness • May be associated with otalgia, otorrhoea, vesicles, parotid mass or tympanic membrane abnormality	• Bell's palsy is idiopathic facial palsy and therefore a diagnosis of exclusion • If sparing of forehead muscles, consider stroke or other central causes • Steroid therapy may be initiated if no associated findings • Consider anti-viral treatment if associated with vesicles • Protection of the eye from a corneal abrasion is paramount. Apply Lacrilube and tape the eye shut at night	• Contact ENT AO – Category 1
Neoplasm		Top
Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Persistent odynophagia/ dysphagia especially when associated with unilateral otalgia > 2 weeks • Weight loss • Hoarseness >2 weeks if no obvious cause • Smoker, Alcohol++ Examination: • Head and neck mass (including neck node) or ulceration persistent > 2 weeks		• Contact ENT AO – Category 1 • If noisy breathing/breathing difficulty – refer immediately to ED

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines

Quinsy

Top

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Preceding mild sore throat • Severe odynophagia Examination: • Unilateral tonsillar displacement • Uvula displacement to contralateral side • Trismus • Cervical lymphadenopathy	• Note persistent unilateral tonsillar enlargement may represent an underlying malignancy	Refer immediately to ED

Sialedenitis – acute or recurrent

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Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Salivary gland swelling associated with eating • Dental caries • Trauma Examination: • Tender salivary gland • Calculus may be palpable in floor of mouth on bimanual palpation	• Hydration • Culture purulent discharge • Anti-staphylococcal antibiotics: Augmentin	• If recurrent salivary gland swelling – Category 2 • If associated with hard mass, contact ENT AO – Category 1 • If non-resolving despite medical therapy – refer immediately to ED

Sleep apnoea/disturbed sleep in children

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Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Snoring • Witnessed apnoeas • Waking unrefreshed • Hyperactive • Irritable • Inattention • Failure to thrive • Dysphagia Examination: • Tonsillar hypertrophy • Mouth breathing • Adenoid facies (underdeveloped thin nostrils, short upper lip, prominent upper incisors, crowded teeth, narrow upper alveolus, high-arched palate, hypoplastic maxilla)	• Referral for sleep studies	• Presentation of current sleep studies • Category 2 • Severe symptoms – Category 1

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines

Tonsillar haemorrhage

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Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Post tonsillectomy haemorrhage (usually within first 2 weeks) Examination: • Fresh bleeding or clot may be seen	• Topical therapy with ice cubes	Refer immediately to ED

Tonsillitis/peritonsillits

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Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Odynophagia Examination: • Tonsilar exudate/swelling * • Odynophagia • Fever >38^0 * • Tender cervical lymphadenopathy * • Absence of cough * • Noisy breathing/breathing difficulty/voice change	• Most sore throats are viral and do not require antibiotics • If more signs (marked with *) present, this increases possibility of Beta haemolytic streptococcal tonsillitis. In these cases consider targeted antibiotic therapy • If acute asymmetry of tonsils in absence of trismus/uvula deviation, this may represent peritonsillitis for which antibiotic treatment is indicated	• 6 episodes in the last 12 months OR 4 episodes per year in the past 2 years OR 2 episodes per year for the past 3 years – Category 3 • Acute episode unable to tolerate fluids/non-resolution despite optimal medical management – refer immediately to ED • **Noisy breathing/breathing difficulty/voice change/severe odynophagia** – refer immediately to ED

Nasal and Sinus

Acute Bacterial Rhinosinusitis (ABRS)*

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Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
Inflammation of the nose and the paranasal sinuses History: May be preceded by common cold (symptoms <10 days) Increase symptoms after 5 days or persistent symptoms >10days – acute post viral rhinosinusitis Possibility of ABRS with presence of at least 3 symptoms & signs of: • Severe local pain (mainly unilateral) – typically worsened by leaning forwards with associated overlying tenderness • Fever (>38°C)	• CRP • ESR • Typically upper respiratory pathogens - *S. pneumoniae,* Haemophilus influenza, and *M. catarrhalis* • **Microbiology and CT/plain film imaging not recommended** • Most cases (80%) resolve without antibiotic in 2 weeks • Daily intranasal corticosteroids as monotherapy / 5 days prednisolone 25mg od or combined with antibiotics helpful for symptom control • Amoxycillin or penicillin if severe ABRS • Saline nasal douche	• Visual disturbance/signs, neurological signs/ frontal swelling/severe unilateral or bilateral headache – refer immediately to ED • Severe ABRS despite primary care management – refer immediately to ED * taken from EPOS[3] http://www.rhinologyjournal.com/Rhinology_issues/EPOS2012execsummary.pdf

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
• Elevated ESR/CRP • 'Double sickening' deterioration after initial milder phase of illness Examination: • Purulent rhinorrheoa (mainly unilateral) Note: Unilateral purulent rhinorrhoea may be due to a foreign body in a child		

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Chronic rhinosinusitis (CRS)*

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
Inflammation of the nose and the paranasal sinuses History: • ≥4 months • Presence of two or more symptoms (one of which should be either nasal blockage/obstruction/congestion or nasal discharge (anterior/posterior nasal drip) • ± facial pain/pressure • ± reduction or loss of smell Examination: • Purulent rhinorrheoa • No polyps (CRSsNP) • Nasal polyps (CRSwNP) Note: Unilateral purulent rhinorrhoea may be due to a foreign body in a child	• Topical nasal steroids • Nasal saline douche • Antihistamines if allergic • If previous diagnosis of nasal polyps and recalcitrant to topical steroids, consider flixonase nasules I bd 6 weeks or pulse steroid (prednisolone 25 mg od 5 days) • **Microbiology not recommended**	• Visual disturbance/signs, epistaxis, neurological signs/ frontal swelling/severe unilateral or bilateral headache – refer immediately to ED • No improvement after 4 weeks medical treatment – Category 3 • Bilateral nasal polyps - Category 3 • Presentation of CT Sinuses required (film or Disc) * taken from EPOS[3] http://www.rhinologyjournal.com/Rhinology_issues/EPOS2012execsummary.pdf

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Acute nasal fracture

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Note mechanism of injury • Epistaxis • Nasal obstruction • Neurological sequelae Examination: • Deviation of nasal bridge • Septal haematoma • Evidence of skull base fracture – CSF rhinorrhoea/otorrhoea, racoon eyes, Battle's sign. Cranial nerve signs	• **First aid measures including cool compress and pressure over nostrils to manage epistaxis** • **Imaging is not indicated for simple nasal fractures** unless co-existent fractures, intracranial injury suspected or high force mechanism of injury	• If obvious new nasal bridge deviation or other signs listed in Examination section – refer same day to ED • If swelling predicating evaluation – refer ED in 5 days Note: nasal fractures must be reduced <2 weeks for best results

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Foreign bodies

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • History of insertion of foreign body • Chronic, offensive, purulent unilateral discharge	• Do not attempt direct removal unless experienced and have adequate equipment as otherwise can merely push the foreign body further necessitating general anaesthetic removal	Refer immediately to ED **Note: Batteries can corrode the nasal mucosa within hours and patients should attend for review A.S.A.P.**

Otology

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Benign paroxysmal positional vertigo (BPPV)

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Episodic, motion induced rotatory vertigo Examination: • Positive Hallpike test – characteristic nystagmus MUST be seen (not simply patient's report of dizziness on testing)	• Epley manoeuvre and home Epley manoeuvre, where appropriate, for patient to perform for 3 days • Consider referral to a Vestibular Physiotherapist or Falls and Balance Clinic. Referrals to Vestibular Physiotherapy at the Eye and Ear Hospital are only accepted if they are through the GP Chronic Disease Management Plan. • Neuro-otology (balance/vestibular) testing is not required unless the patient does not have a classic history or examination as described Refer to the Dizziness Primary Care Management Guideline	• If BPPV is refractory to repeated Epley manoeuvres (over 3 days) – Category 3 • Symptoms not resolved after seeing Vestibular Physiotherapist or Falls and Balance Clinic – Category 3 • Co-morbid vestibular or otological conditions – Category 3 • Above but elderly with heightened falls risk – Category 1 • Epley Omniax (**Gandel Philanthropy Balance Disorders Diagnostics)** referral can be considered for: ○ Refractory or recurrent BPPV ○ Patient unable to be assessed or treated at the bedside due to medical comorbidities ○ Suspected central positioning nystagmus. Please address all referrals to "Dear Neurologist" and clearly indicate that the referral is for the Epley Omniax,

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Meniere's disease

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Episodic vertigo associated with aural fullness, tinnitus and fluctuating low frequency sensori-neural hearing loss Examination: • May be normal	• Salt restriction • Consider betahistine 8 to 16mg orally, daily • Consider hydrochlorothiazide 25 mg orally, daily • Neuro-otology (balance/vestibular) testing is not required unless the patient does not have a classic history	• Audiology report to assist with monitoring hearing fluctuations • If symptoms persist despite treatment – Category 3 • Above but elderly with heightened falls risk – Category 1

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
	or examination as described	

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Migrainous vertigo (vestibular migraine)

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Episodic vertigo (or disequilibrium) ± nausea, vomiting & tinnitus • Headache may be absent or temporally dissociated from vertigo Examination: • Generally normal	Consider commencing migraine prophylaxis: • Pizotifen 0.5mg to 1mg orally, at night, up to 3mg daily or • Propanalol 40mg orally, 2 -3 times daily, up to 320mg (avoid in asthmatics) or • Verapamil (sustained release) 160 or 180mg orally, once daily, up to 320 or 360mg daily • Neuro-otology (balance/vestibular) testing is not required unless the patient does not have a classic history or examination as described	• After 3 migraine prophylactic medications have been trialled unsuccessfully – Category 3 • Above but elderly with heightened falls risk – Category 1

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Vestibular neuronitis

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Constant rotatory vertigo for ≥ 24 hours, often with accompanying nausea, vomiting and unsteady gait Examination: • Unidirectional mixed horizontal and torsional nystagmus • Assess for CNS cause: ▪ focal neurological signs ▪ ataxia & nystagmus which is out of proportion for the degree of vertigo (i.e. florid abnormal nystagmus with mild ataxia) ▪ direction-changing or gaze-evoked nystagmus ▪ pure vertical nystagmus (i.e. up-beat or down-beat nystagmus) ▪ other concurrent eye movement abnormalities (gaze palsy, skew deviation)	▪ If CNS signs present patients should be urgently referred for neurological consultation or attend an Emergency Department ▪ Prednisolone 125mg daily for 3 days, reducing by 25mg every 3 days until taking 25mg daily for 3 days, then 12.5mg daily for 3 days, ▪ Acute symptoms may be managed by vestibular sedatives (e.g. prochlorperazine 5 to 10mg orally 3-4 times daily). The duration of prescribing these sedatives should be limited to no more than a few days to minimize side-effects and encourage recovery ▪ Neuro-otology (balance/vestibular) testing is not required unless the patient does not have a classic history or examination as described ▪ Refer to a Vestibular Physiotherapist. Referrals to Vestibular Physiotherapy at the Eye and Ear Hospital are only accepted if they are through the GP Chronic	• If there is no evidence of significant recovery of balance within 2 weeks – Category 1

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
	Disease Management Plan.	

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Barotrauma

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Acute onset of vertigo or disequilibrium associated with pressure change usually caused by air flight or diving. There may be associated hearing loss, imbalance and tinnitus Examination: • Middle ear effusion • Nystagmus on pneumatic otoscopy • Tuning forks tests may suggest conductive or sensorineural loss	• Possibility of a perilymph fistula between the inner ear and middle ear must be considered	• Refer immediately to ED

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Foreign bodies

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • History of insertion of foreign body Examination: • Usually seen	• If live insect, drown with olive oil • Syringing may be attempted • Do not attempt direct removal unless experienced and have adequate equipment as otherwise may push the foreign body further necessitating general anaesthetic removal	• Refer immediately to ED

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Otitis externa – Acute

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Otalgia, hearing loss, otorrhoea, pruritic ear canal • History ear canal trauma e.g. cotton bud/hair pin use • Diabetic history Examination: • Oedematous ear canal (TM may not be seen) • Purulent otorrhoea • Tuning forks consistent with conductive or sensorineural loss	• Protect ear from water exposure • Aural toilet (not syringing) if experienced • Tissue spear can be used for dry mopping • Topical antibiotic/steroid drops • Consider topical antifungal/steroid drops if fungal (e.g. spores) • If unresponsive to initial management , prescribe culture directed topical drops • If perforation present, use Ciloxan or consider locacorten vioform drops	• **If otalgia disproportionate with signs in diabetic patient non-responsive to topical therapy –** refer immediately to ED **to exclude skull base osteomyelitis** • If ear canal occluded by oedema / unable to clear discharge – refer immediately to ED

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Otitis media – Acute

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Otalgia, hearing loss, otorrhoea • Fever • Hx recent URTI Examination: • Bulging inflamed tympanic membrane, mucopurulent discharge • Tuning forks consistent with conductive or sensorineural loss	Note: spontaneous resolution may occur in 70-80% of untreated children in 1-2 weeks • Analgesic/symptomatic relief • In some groups antibiotics are required (children ≤2 years, history of febrile seizures, presence of fever >39^{0}C, Abor./Tor. Strait Islanders, neurological signs, no resolution after 24 hours, immunocompromise, only hearing ear, cochlear implant)	• **If neurological signs/mastoiditis –** refer immediately to ED • If recurrent episodes – Category 3

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Otitis media – Chronic Suppurative

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Otaligia, hearing loss, otorrhoea Examination: • Perforation of drum (especially attic or postero-superiorly granulation tissue/bleeding/keratin) • Wax plug overlying postero-supero quadrant of ear drum • Tuning forks consistent with conductive or sensorineural loss	• Protect ear from water exposure • Aural toilet (not syringing) if experienced • Topical Ciloxan® ear drops	• **If neurological signs/mastoiditis – refer immediately to ED** • If persistent symptoms despite antibiotic therapy – Category 2

SYMPTOMS

Nasal and Sinus

Top

Alternating bilateral nasal obstruction

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Bilateral alternating nasal obstruction • Rhinorrhoea • Sneezing • Bilateral epiphora • Itchy eyes/throat/nose • *Unilateral epiphora, diplopia, unilateral hearing loss* • Assess if intermittent or persistent symptoms through year • Enquire regarding triggering factors • Atopic Examination:	• Trial daily topical nasal steroid spray for 6 weeks. Consider adjunctive antihistamines • Arrange skin prick testing for allergy • Advise against prolonged use of decongestants (not longer than 1 week) due to risk of rhinitis medicamentosa • Consult ARIA guidelines http://www.whiar.org/docs/ARIAReport_2010.pdf	• Alternating nasal obstruction with positive allergy testing despite primary care management suggested by ARIA – referral to local allergist • Alternating nasal obstruction with negative allergy testing despite primary care management suggested by ARIA – Category 3 • Alternating nasal obstruction with side predominance despite primary care management suggested by ARIA – Category 3 • Presence of items *italicised* in Evaluation – Category 1

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
• Rhinitic mucosa / inferior turbinates • Note: a prominent inferior turbinate may be mistaken for a polyp (the former is less translucent / sensitive to touch and decreases in size with decongestion) • *Obstructing intra nasal mass* • *Unilateral middle ear effusion*		(contact ENT Registrar)

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Epistaxis – persistent or recurrent

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Trauma (including nose picking), recent nasal surgery • Anterior or posterior epistaxis on history • Coagulopathy, anticoagulants • Nasal obstruction, *change in sense of smell, epiphora, diplopia* Examination: • Bleeding stigmata over Little's area/posterior pharyngeal wall/*intranasal mass*	• Direct pressure to nostrils compressing Little's area • Prescribe topical bactroban qds to Little's area for anterior epistaxis • AgNO3 cautery following topical anaesthesia, if not resolving and clinician has previous experience • Evaluation of blood picture and coagulation screen if recurrent or significant episode	• Persistent bleeding despite first aid measures– refer immediately to ED • Recurrent epistaxis on background of nasal trauma – Category 2 • Recurrent epistaxis with no overt cause but associated additional history and items *italicised* in Evaluation – Category 1 (contact ENT Registrar)

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Unilateral nasal obstruction

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Persistent unilateral nasal obstruction • (If intermittent, consider management as per alternating bilateral nasal obstruction associated with septal deivation) • Trauma, recent nasal surgery • *Change in sense of smell, unilateral epiphora, diplopia, unilateral hearing loss* Examination: • Septal deviation • *Obstructing intra nasal mass* • *Unilateral middle ear effusion*	• Trial daily topical nasal steroid spray for 6 weeks	• Septal deviation with persistent unilateral nasal obstruction despite trial of nasal steroid spray – Category 3 • Persistent nasal obstruction with associated additional history and items *italicised* in Evaluation – Category 1 (contact ENT Registrar)

Otology

Top

Dizziness/disequilibrium – Non-specific

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
Presentation:	• Sedative & vestibular	• If suspected Benign

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
• Imbalance ± falls usually in elderly patients • Multi-sensory dizziness, often with more than one aetiology (e.g. vision, peripheral sensation, vestibular hypofunction, hypothyroidism) Examination: • Hallpike testing (many elderly patients have co-morbid Benign Paroxysmal Positional Vertigo (BPPV)) • Assess peripheral sensation, vision, bedside vestibular function testing: ▪ Hallpike Test ▪ Head Impulse Test ▪ Peripheral vestibular nystagmus (unilateral beating away from the effected ear)	suppressants (e.g. stemetil, diazepam) may exacerbate presentation • DEXA bone density scan and bone protection medication (calcium & vitamin D at a minimum) • Specialist referral as appropriate: consider geriatrician, ophthalmologist (if visual component suspected, e.g. cataracts), neurologist (if neurological component suspected, e.g. peripheral neuropathy) • Consider referral to a Falls and Balance Clinic Refer to Dizziness Primary Care Management Guideline	Paroxysmal Positional Vertigo see BPPV • Evidence during bedside examination of vestibular dysfunction – Category 3 • Above but elderly with heightened falls risk – Category 1

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Hearing Loss – Bilateral Recent

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • <3 week history • Note history cotton bud use, recent URTI • Decreased bilateral hearing loss • May be associated with vertigo, tinnitus, otalgia, otorrhoea Examination: • Cerumen, effusion or normal findings • Tuning forks consistent with conductive or sensorineural loss	• If cerumen present, use dissolving drops and irrigation or suction if available. Consider referral to wax cleaning clinic • If otitis externa, prescribe topical antibiotic steroid drops • If ear canal clear, arrange audiology testing Refer to Hearing Loss Primary Care Management Guideline	• If history less than 1 week and examination unremarkable – refer immediately to ED • If unable to clear cerumen / otorrhoea recalcitrant to treatment – refer to ED Adults • If >1 week , clear canal and associated with vertigo and/or tinnitus – Category 2 Children • If >1 week and clear canal – Category 2 • If >1 week, clear canal and with associated ENT conditions (e.g. snoring or swallowing difficulty) – Category 2

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Hearing Loss – Bilateral Chronic

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • >3 week history • May be associated with vertigo, tinnitus, otalgia, otorrhoea Examination: • Cerumen, effusion or normal findings • Tuning forks consistent with	• If cerumen present, use dissolving drops and irrigation or suction if available. Consider referral to wax cleaning clinic • If ear canal clear, arrange audiology testing requesting air and bone conduction thresholds Adults	• If unable to clear cerumen / otorrhoea recalcitrant to treatment – refer to ED Adults • If ear canal clear and associated with vertigo and tinnitus – Category 3 Children • If ear canal clear and with associated ENT conditions

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
conductive or sensorineural loss	◆ No referral required for symmetrical hearing loss. Arrange community audiology review for consideration of hearing aids Refer to Hearing Loss Primary Care Management Guideline	(e.g. snoring or swallowing difficulty) – Category 2

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Hearing Loss – Unilateral Sudden

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: ◆ <3 week history ◆ May be associated with vertigo, tinnitus, otalgia, otorrhoea Examination: ◆ Cerumen, effusion or normal findings ◆ Tuning forks consistent with conductive or sensorineural loss	◆ If cerumen present, use dissolving drops and irrigation or suction if available. Consider referral to wax cleaning clinic Refer to Hearing Loss Primary Care Management Guideline	◆ **For sudden onset hearing loss in absence of clear aetiology and/or associated with vertigo and tinnitus** – refer immediately to ED ◆ If unable to clear cerumen/otorrhoea recalcitrant to treatment– refer to ED

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Hearing Loss– Unilateral Chronic

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: ◆ >3 week history ◆ May be associated with vertigo, tinnitus, otalgia, otorrhoea Examination: ◆ Cerumen, effusion or normal findings ◆ Tuning forks consistent with conductive or sensorineural loss	◆ If cerumen present, use dissolving drops and irrigation or suction if available. Consider referral to wax cleaning clinic ◆ If otitis externa, prescribe topical antibiotic /steroid drops Adults or children ◆ If ear canal clear, arrange audiology testing Refer to Hearing Loss Primary Care Management Guideline	◆ If unable to clear cerumen / otorrhoea recalcitrant to treatment – refer to ED Adults ◆ If asymmetrical hearing or middle ear effusion – Category 2 ◆ If canal clear and associated with vertigo and tinnitus – Category 2 Children ◆ If middle ear effusion – Category 2

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Otalgia in the setting of normal otoscopic examination

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: ◆ Enquire and examine referred sites of otalgia: teeth, tonsils, TMJ, throat, tongue, sinuses, cervical spine, neck	◆ Manage associated conditions found on examination	◆ If persistent symptoms after 3 weeks with no overt aetiology – Category 2

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Tinnitus – Chronic Bilateral

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: ◆ Noise exposure ◆ Hearing loss	◆ Arrange audiology testing ◆ If cerumen present, use dissolving drops and irrigation or suction if available. Consider referral to wax	◆ If unable to clear cerumen / otorrhoea recalcitrant to treatment – refer to ED

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
Examination: • Cerumen, effusion or normal findings • Tuning forks consistent with conductive or sensorineural loss	cleaning clinic • No referral required if symmetrical, bilateral hearing loss. Give tinnitus advice. Refer cognitive behavioural therapy/audiology for masking aids if disabling Refer to Tinnitus Primary Care Management Guideline	

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Tinnitus – Unilateral or Recent Onset

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • May be associated with vertigo, hearing loss, otalgia, otorrhoea Examination: • Cerumen, effusion or normal findings • Tuning forks consistent with conductive or sensorineural loss	• If cerumen present, use dissolving drops and irrigation or suction if available. Consider referral to wax cleaning clinic • Arrange audiology testing Refer to Tinnitus Primary Care Management Guideline	• For unilateral tinnitus – Category 2 • If unable to clear cerumen / otorrhoea recalcitrant to treatment – refer to ED

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Tinnitus – Pulsatile

Evaluation	Primary Care Management	Threshold Criteria / Referral Guidelines
History: • Patient may describe as simultaneous with pulse • May be associated with vertigo, hearing loss, otalgia, otorrhoea, bleeding from canal Examination: • Pulsatile mass behind tympanic membrane, cerumen, effusion or normal findings • Tuning forks consistent with conductive or sensorineural loss	• Auscultate carotid vessels to assess for bruits • Arrange audiology testing • Manage otitis externa, cerumen Refer to Tinnitus Primary Care Management Guideline	• If persistent symptoms despite management – Category 2 (to exclude glomus jugulare / tympanicum tumour)

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Vertigo

Refer to the following in these referral guidelines:

- Benign paroxysmal positional vertigo
- Meniere's Disease
- Migrainous Vertigo
- Vestibular Neuronitis
- Barotrauma