LMU DeBusk College of Osteopathic Medicine
LINCOLN MEMORIAL UNIVERSITY

FARRAGUT ENT & ALLERGY

WHEN DO I REFER?
MARK T. GURLEY M.D.

OBJECTIVES

- To Discuss Common situations that might need referral.
- To Identify and discuss common Red Flag signs and symptoms.
- Discuss common referral scenarios related to nasolaryngoscopy that are encountered in primary care.

- Indications
- Procedure
- Complications

TONSILLECTOMY

TONSILLECTOMY INDICATIONS

- Recurrent Severe infections- fever over 101, strep positive, LAD.
- Sleep Disordered Breathing.
- Modifying Factors- antibiotic resistance, PFAPA

Table 4. Summary of Evidence-Based Statements

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Statement	Action	Strength
1. Watchful waiting for recurrent throat infection	Clinicians should recommend watchful waiting for recurrent throat infection if there have been <7 episodes in the past year, <5 episodes per year in the past 2 years, or <3 episodes per year in the past 3 years.	Strong recommendation
2. Recurrent throat infection with documentation	Clinicians may recommend tonsillectomy for recurrent throat infection with a frequency of at least 7 episodes in the past year, at least 5 episodes per year for 2 years, or at least 3 episodes per year for 3 years with documentation in the medical record for each episode of sore throat and ≥1 of the following: temperature >38.3°C (101°F), cervical adenopathy, tonsillar exudate, or positive test for group A beta-hemolytic streptococcus.	Option
3. Tonsillectomy for recurrent infection with modifying factors	Clinicians should assess the child with recurrent throat infection who does not meet criteria in Key Action Statement 2 for modifying factors that may nonetheless favor tonsillectomy, which may include but are not limited to: multiple antibiotic allergies/intolerance, PFAPA (periodic fever, aphthous stomatitis, pharyngitis, and adenitis), or history of >1 peritonsillar abscess.	Recommendation
4. Tonsillectomy for obstructive sleep-disordered breathing	Clinicians should ask caregivers of children with obstructive sleep-disordered breathing (oSDB) and tonsillar hypertrophy about comorbid conditions that may improve after tonsillectomy, including growth retardation, poor school performance, enuresis, asthma, and behavioral problems.	Recommendation
5. Indications for polysomnography	Before performing tonsillectomy, the clinician should refer children with obstructive sleep-disordered breathing (oSDB) for polysomnography (PSG) if they are <2 years of age or if they exhibit any of the following: obesity, Down syndrome, craniofacial abnormalities, neuromuscular disorders, sickle cell disease, or mucopolysaccharidoses.	Recommendation
6. Additional recommendations for polysomnography	The clinician should advocate for polysomnography (PSG) prior to tonsillectomy for obstructive sleep-disordered breathing (oSDB) in children without any of the comorbidities listed in Key Action Statement 5 for whom the need for tonsillectomy is uncertain or when there is discordance between the physical examination and the reported severity of oSDB.	Recommendation
7. Tonsillectomy for obstructive sleep apnea	Clinicians should recommend tonsillectomy for children with obstructive sleep apnea (OSA) documented by overnight polysomnography (PSG).	Recommendation
8. Education regarding persistent or recurrent obstructive sleep-disordered breathing	Clinicians should counsel patients and caregivers and explain that obstructive sleep-disordered breathing (oSDB) may persist or recur after tonsillectomy and may require further management.	Recommendation
9. Perioperative pain counseling	The clinician should counsel patients and caregivers regarding the importance of managing posttonsillectomy pain as part of the perioperative education process and should reinforce this counseling at the time of surgery with reminders about the need to anticipate, reassess, and adequately treat pain after surgery.	Recommendation
10. Perioperative antibiotics	Clinicians should not administer or prescribe perioperative antibiotics to children undergoing tonsillectomy.	Strong recommendation against
11. Intraoperative steroids	Clinicians should administer a single intraoperative dose of intravenous dexamethasone to children undergoing tonsillectomy	Strong recommendation
12. Inpatient monitoring for children after tonsillectomy	Clinicians should arrange for overnight, inpatient monitoring of children after tonsillectomy if they are <3 years old or have severe obstructive sleep apnea (OSA; apnea-hypopnea index [AHI] ≥10 obstructive events/hour, oxygen saturation nadir <80%, or both).	Recommendation
13. Postoperative ibuprofen and acetaminophen	Clinicians should recommend ibuprofen, acetaminophen, or both for pain control after tonsillectomy.	Strong recommendation
14. Postoperative codeine	Clinicians must not administer or prescribe codeine, or any medication containing codeine, after tonsillectomy in children younger than 12 years.	Strong recommendation against
15a. Outcome assessment for bleeding	Clinicians should follow up with patients and/or caregivers after tonsillectomy and document in the medical record the presence or absence of bleeding within 24 hours of surgery (primary bleeding) and bleeding occurring later than 24 hours after surgery (secondary bleeding).	Recommendation
15b. Posttonsillectomy bleeding rate	Clinicians should determine their rate of primary and secondary posttonsillectomy bleeding at least annually.	Recommendation

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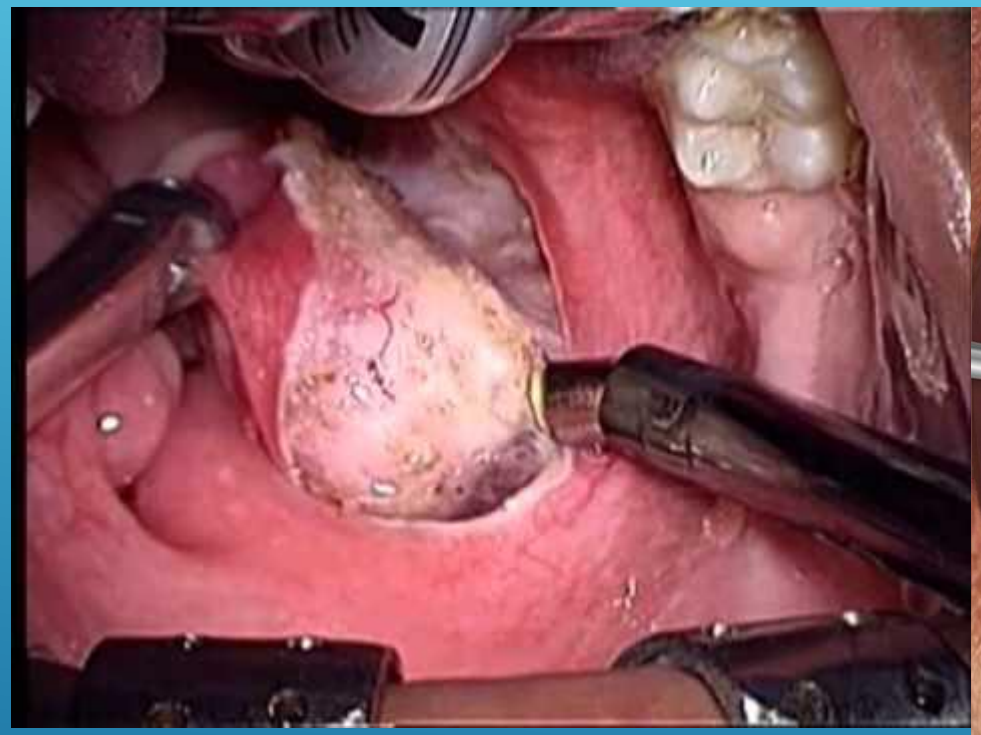
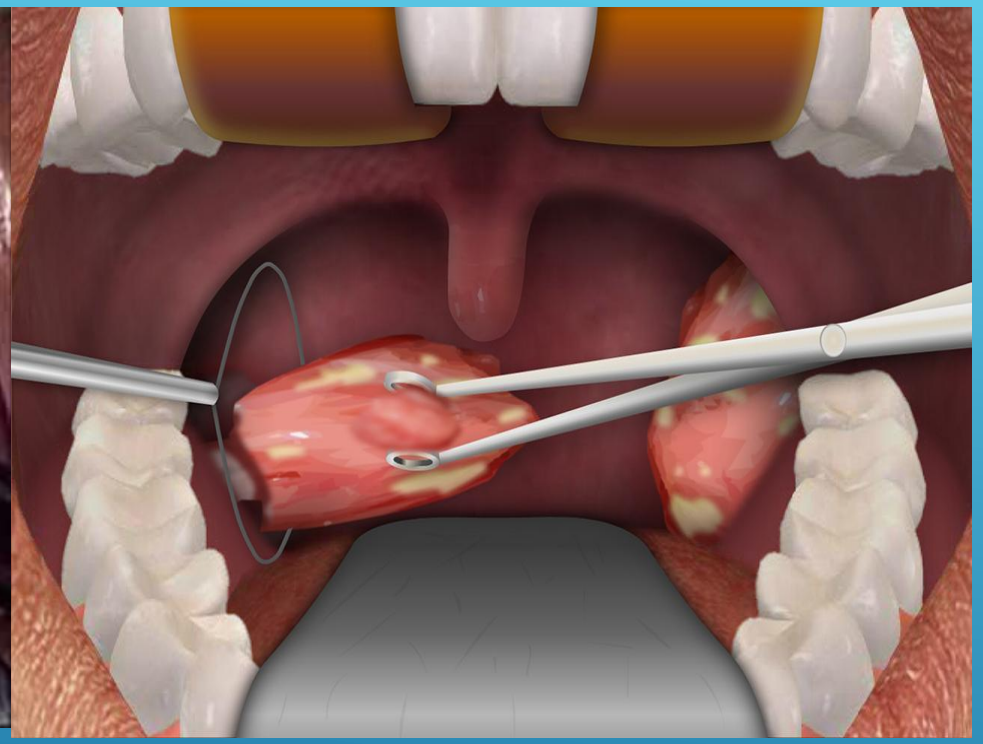
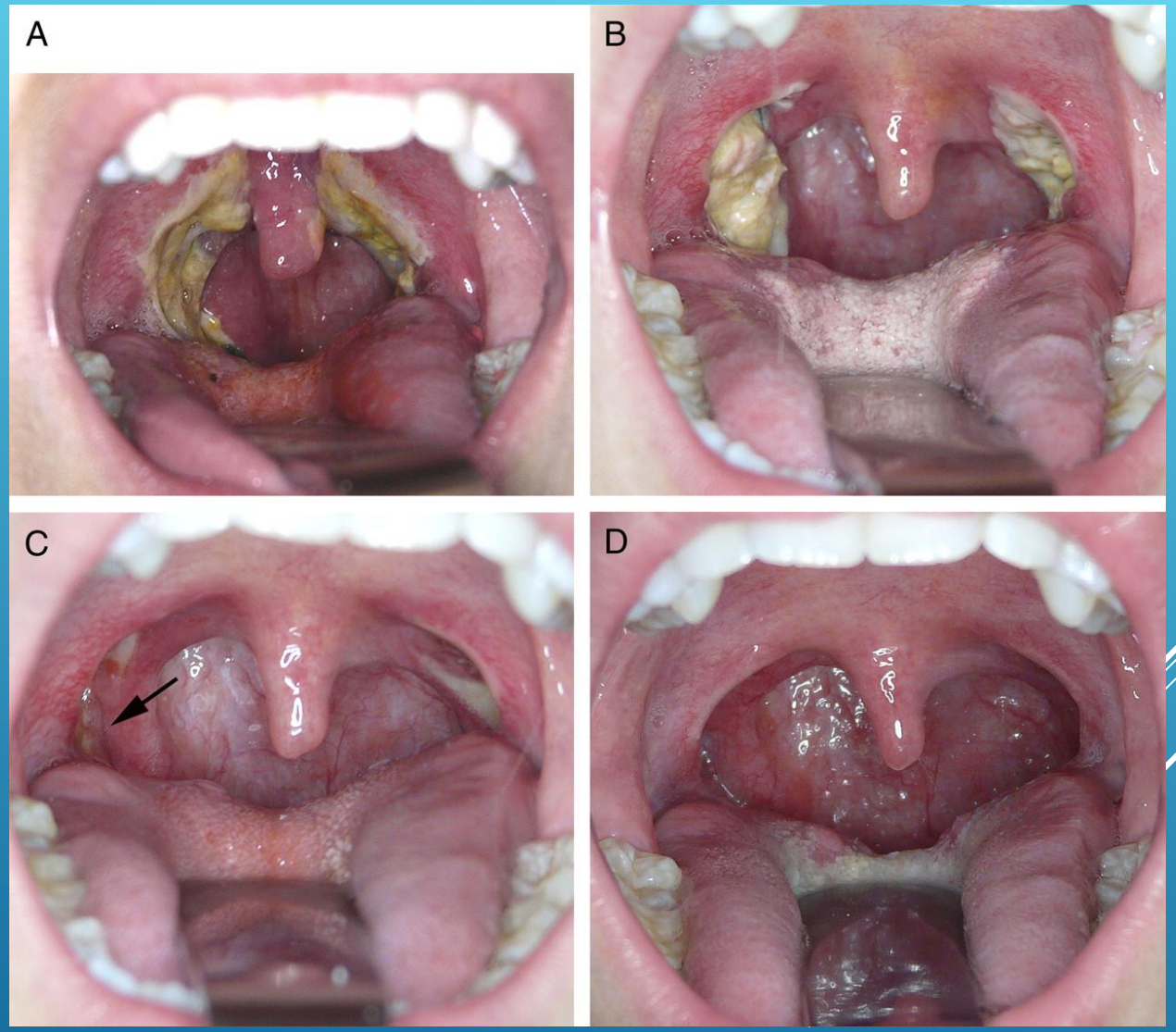




PROCEDURE

COMPLICATIONS

- Bleeding
- Pain
- Dehydration
- Velopharyngeal insufficiency
- Death



TUBES

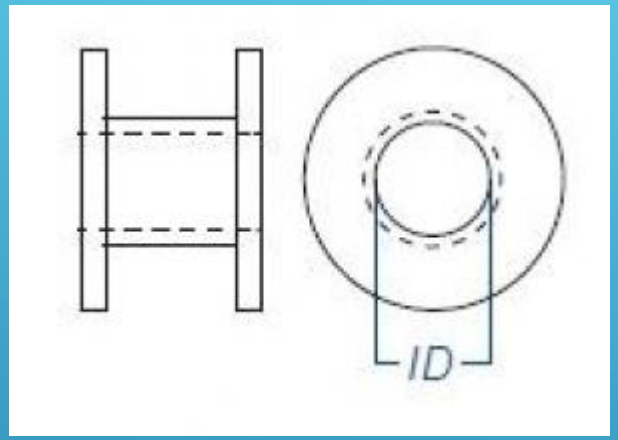
- Indications
- Procedure
- Complications

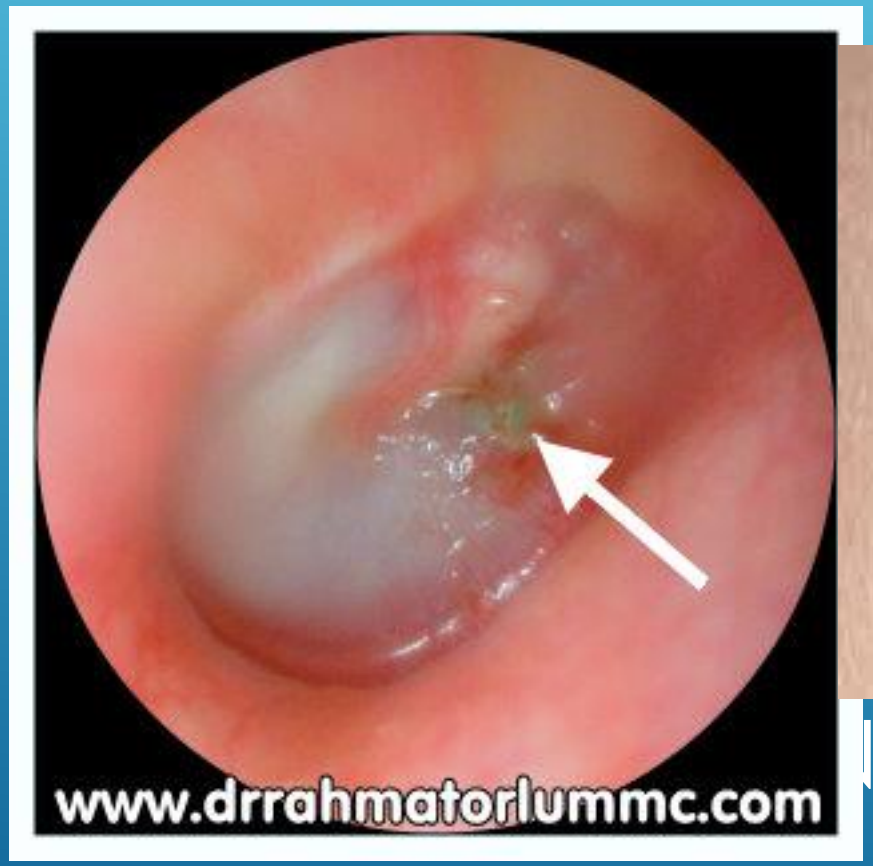
INDICATIONS

- Chronic Bilateral Otitis Media with Effusion (OME) with Hearing Difficulty
- Chronic OME with Symptoms
- Recurrent Acute Otitis Media with Middle Ear Effusion

PROCEDURE

- General Anesthesia
- Multiple types and Sizes of Tubes
- Usually quick
- Post operative Drops?

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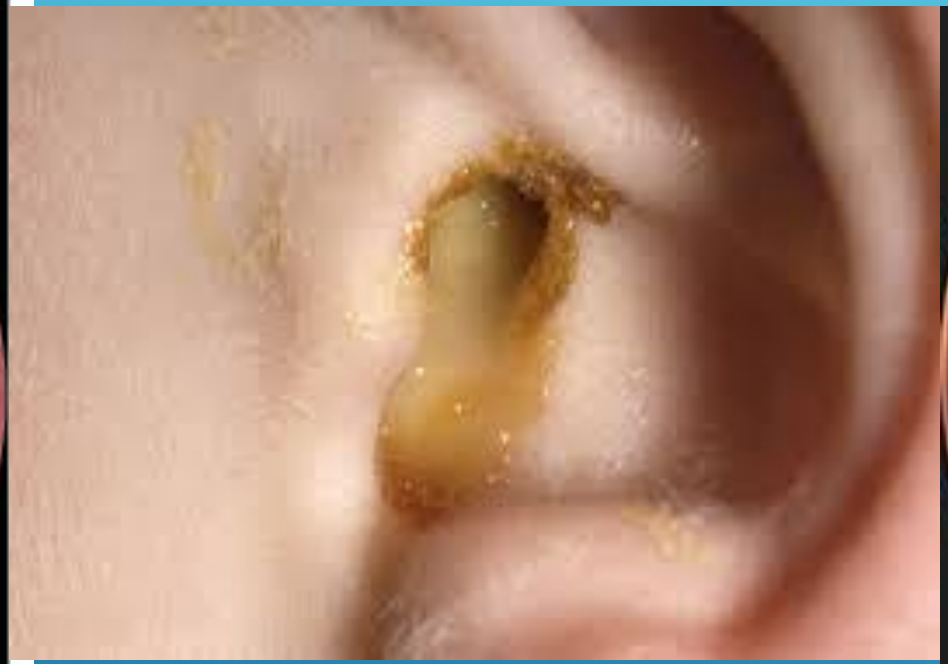

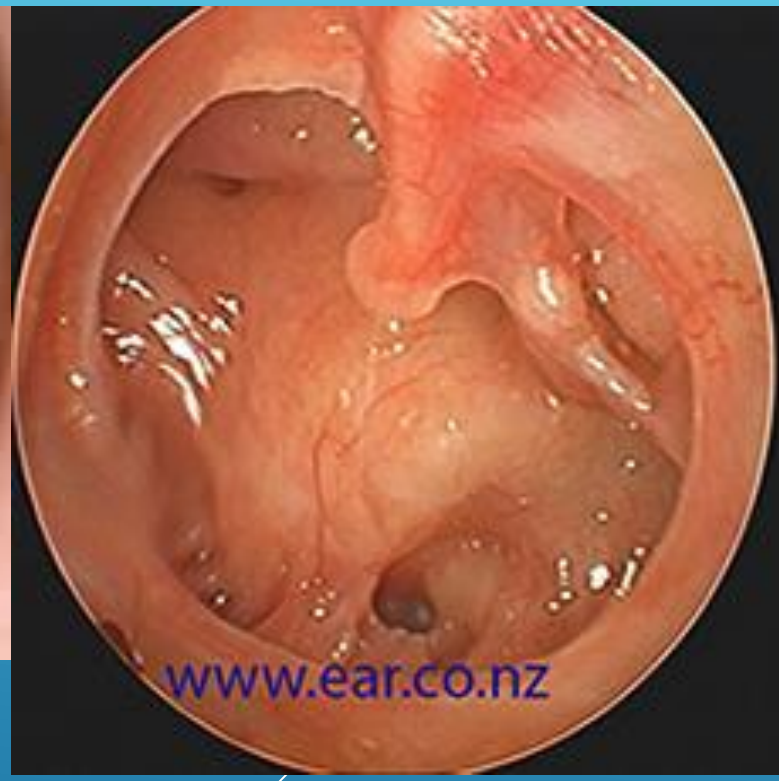
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- Otalgia
- Serous Otitis Media
- Otorrhea
- Sudden Hearing Loss
- Vertigo
- Sore Throat
- Neck Masses
- Hoarseness

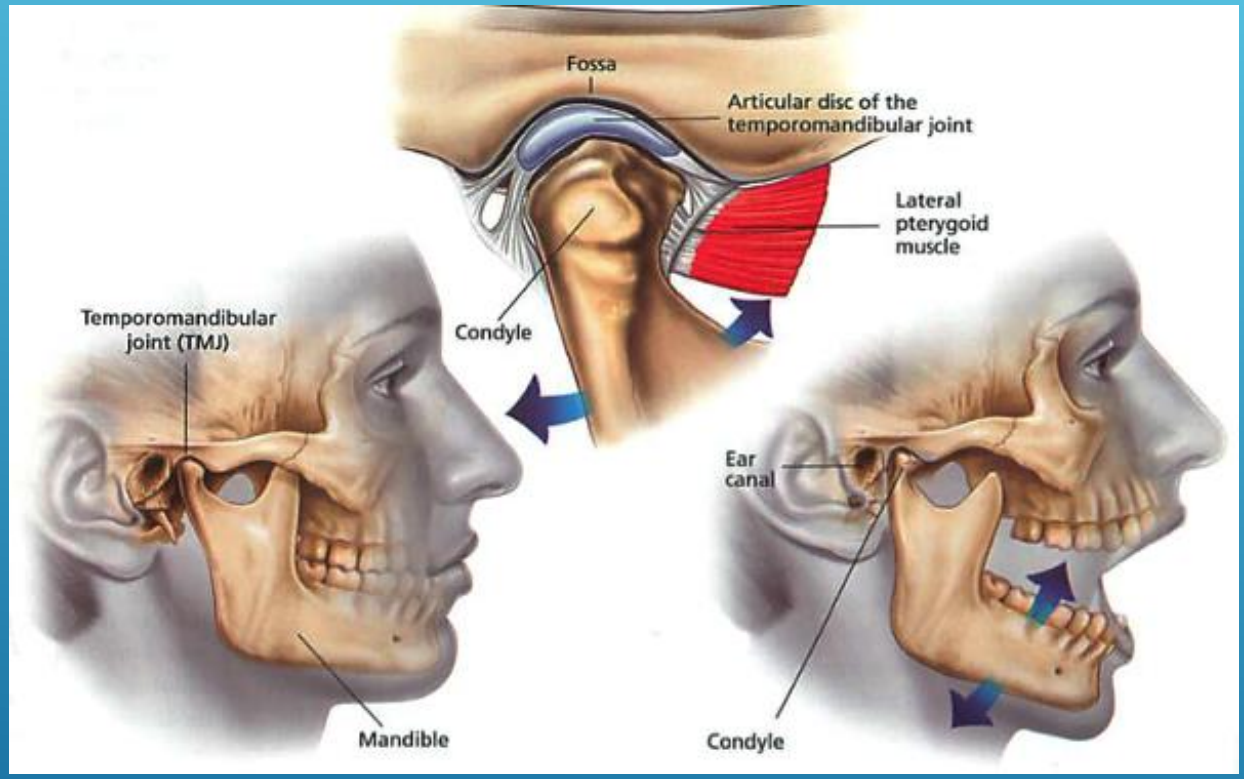
COMMON PRESENTING SIGNS AND DANGERS

OTALGIA

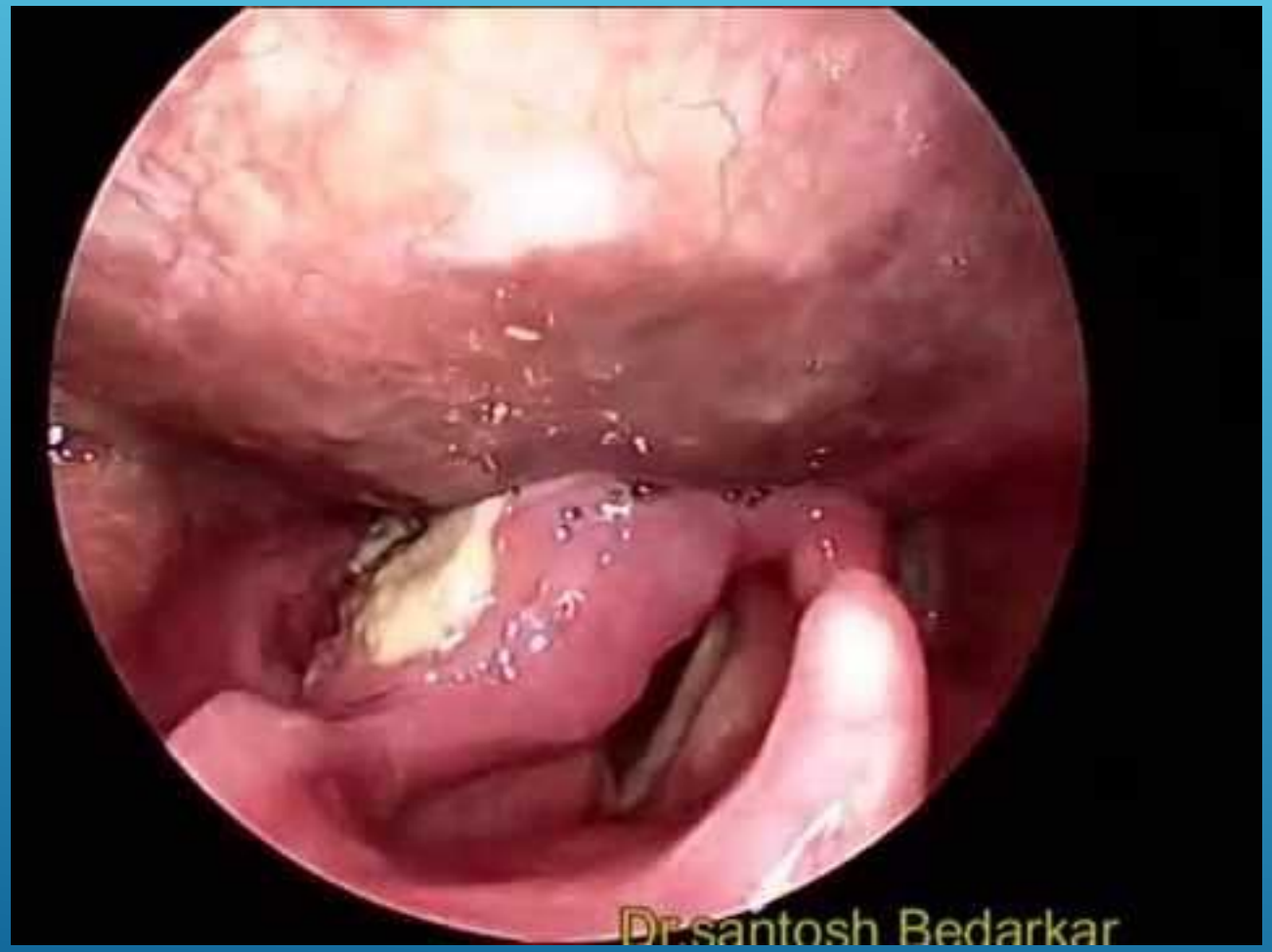
- Unilateral vs Bilateral
- Duration
- Other signs and symptoms

- Can be either unilateral or bilateral.
- Joint crepitus
- Periods of relief when not in use.
- Worsening with chewing.
- Can lead to jaw locking.

OTALGIA: TMJ DISORDERS

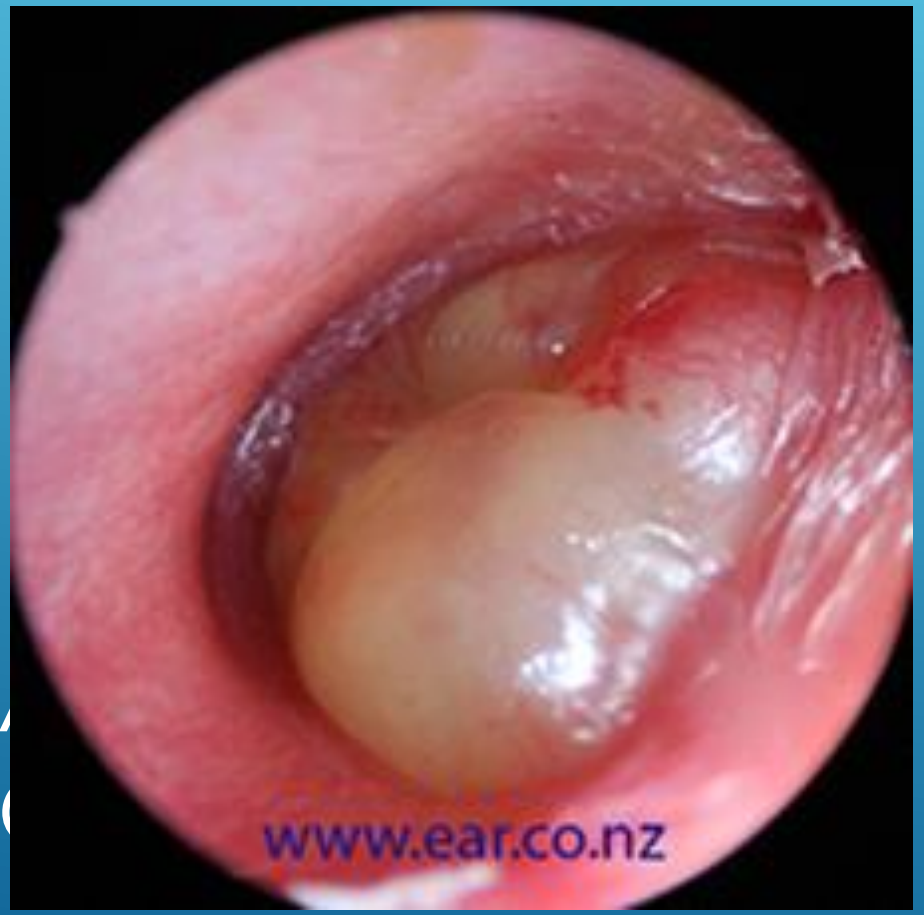

Fossa
Articular disc of the temporomandibular joint
Lateral pterygoid muscle
Temporomandibular joint (TMJ)
Condyle
Ear canal
Mandible
Condyle

OTALGIA



SEROUS OTITIS MEDIA

- Unilateral vs Bilateral
- Duration
- Recent Illnesses



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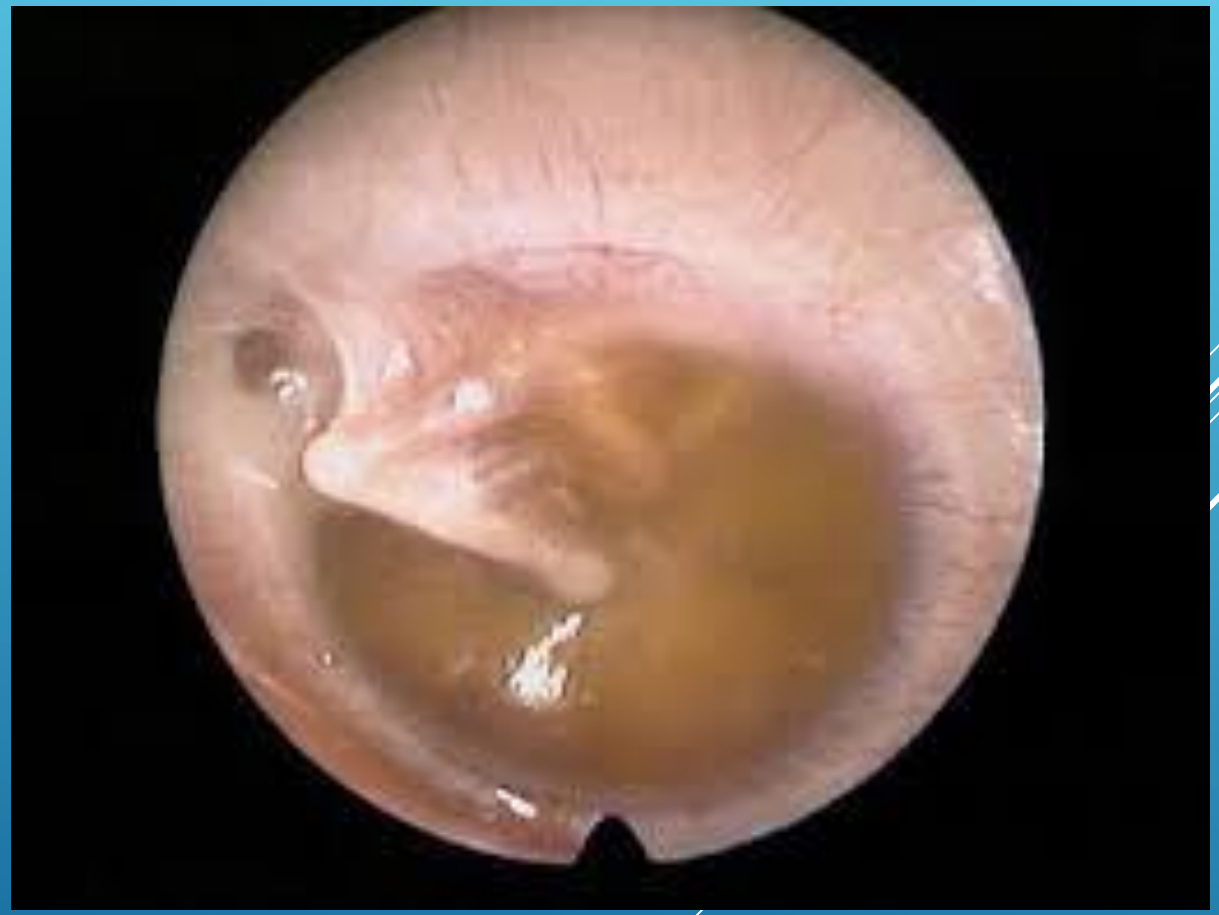

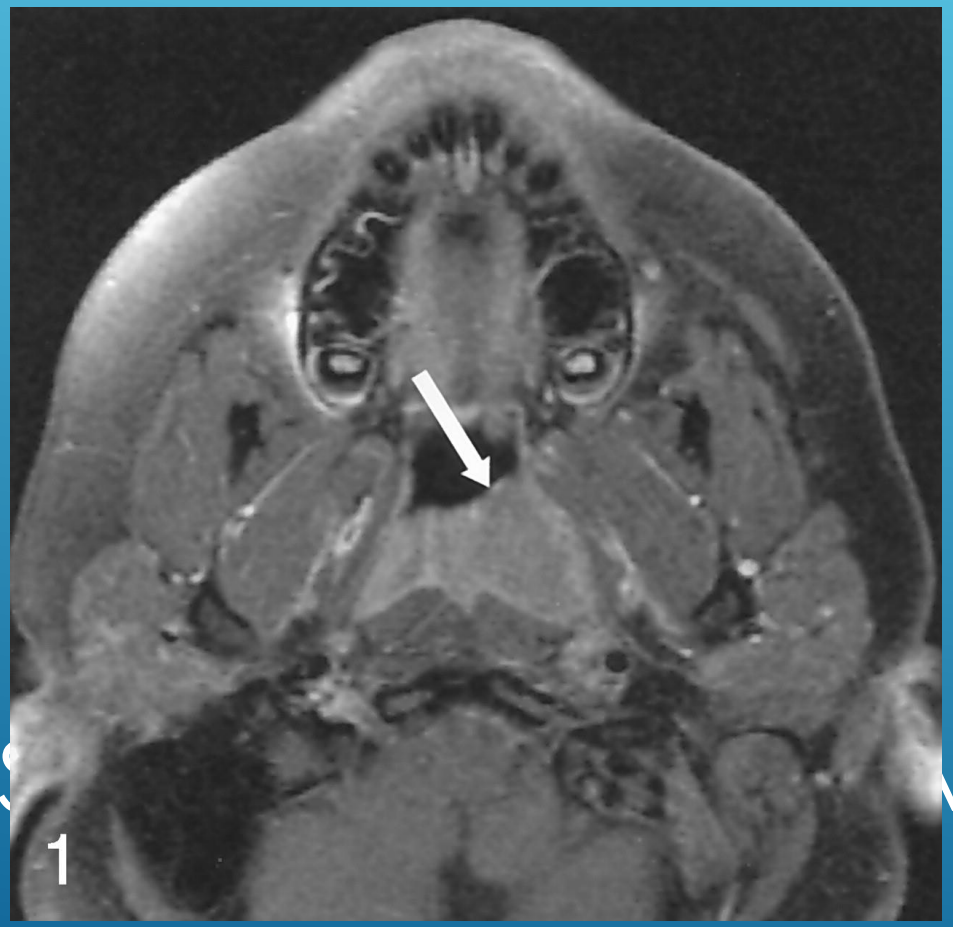
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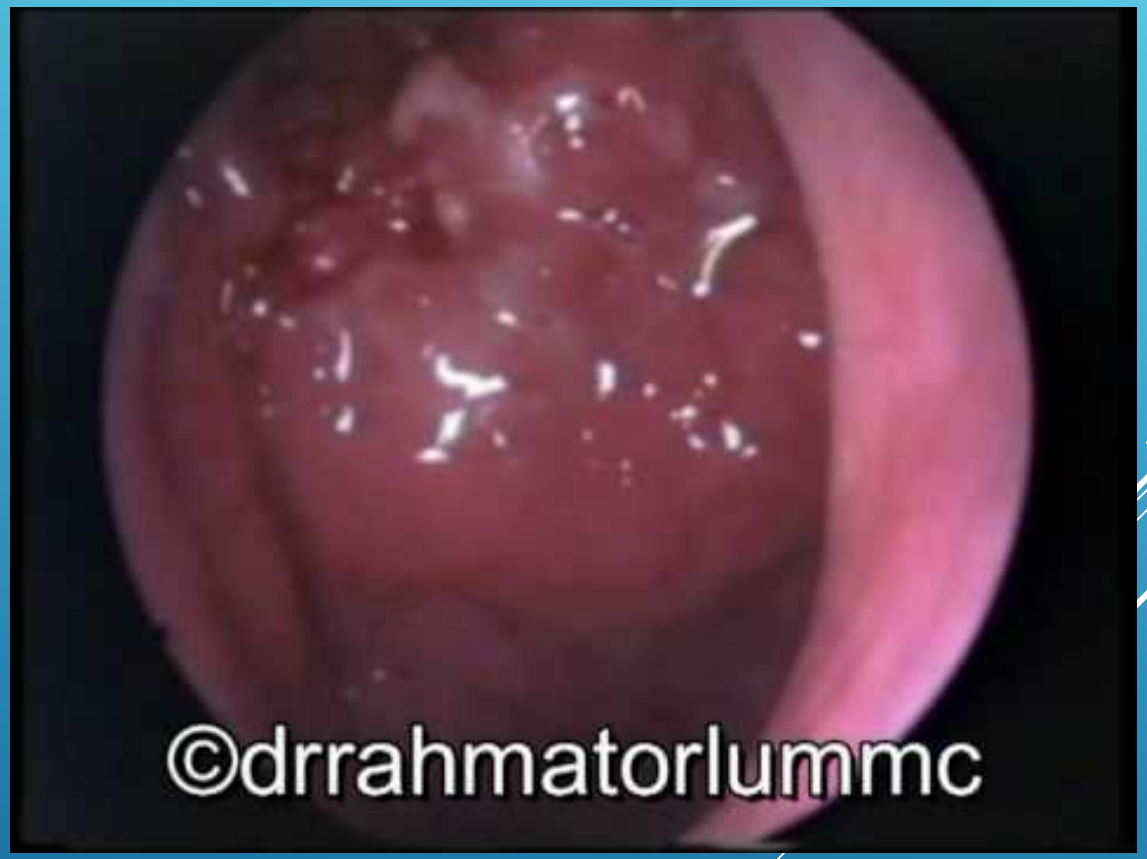
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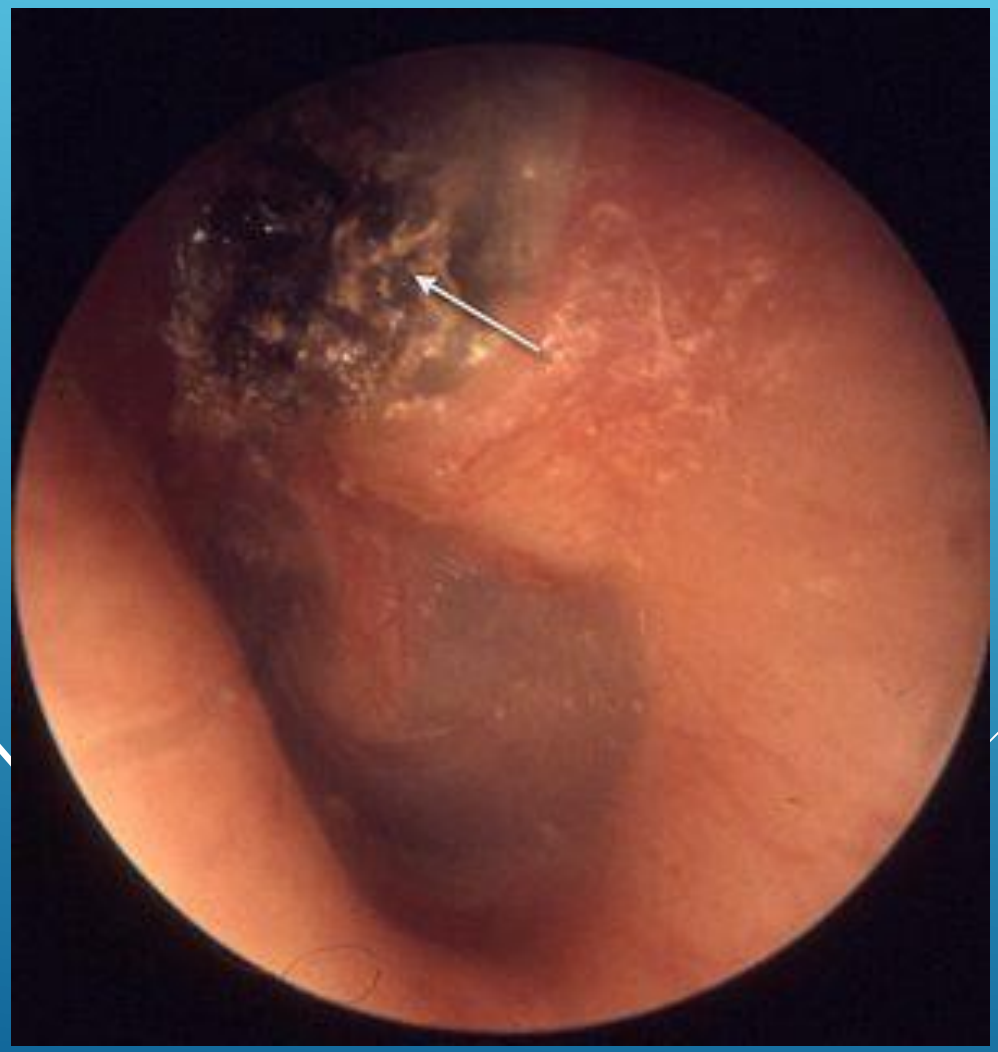
OTORRHEA COMMON

- Perforation
- Cholesteatoma
- Otitis Externa

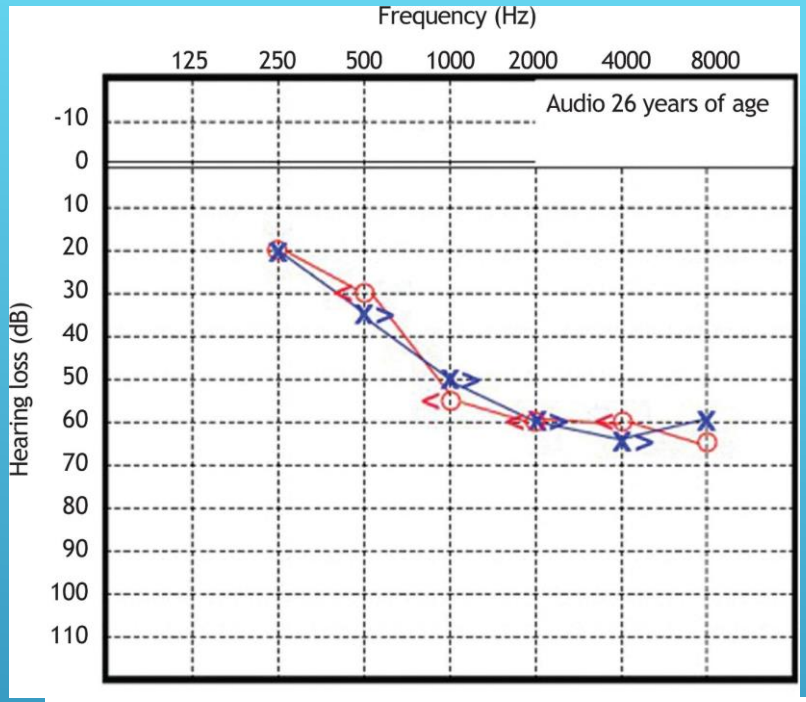


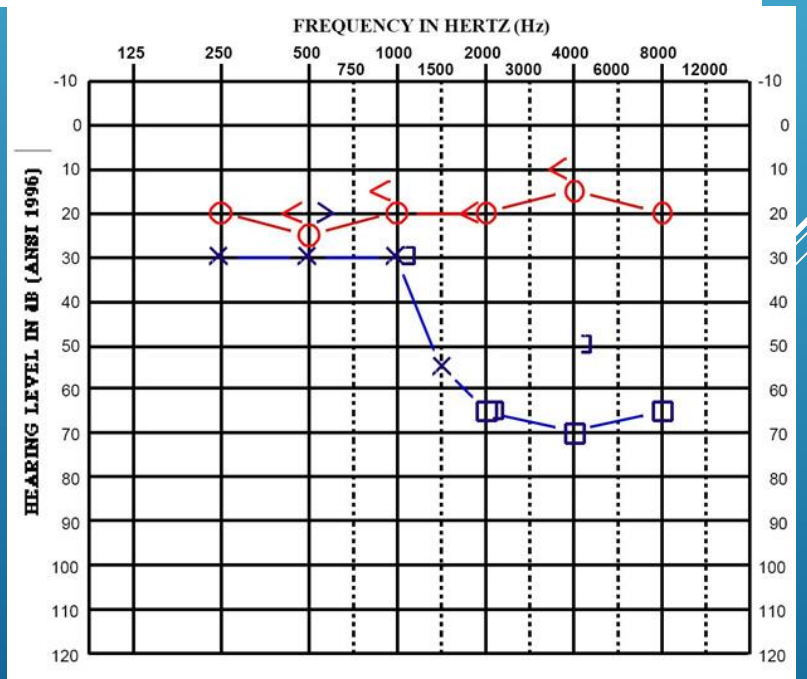
- Duration is Key
- Hearing Loss with other symptoms
- Unilateral vs Bilateral
- Vegetative symptoms
- Other Neurological signs or symptoms

VERTIGO AND HEARING LOSS

HEARING LOSS

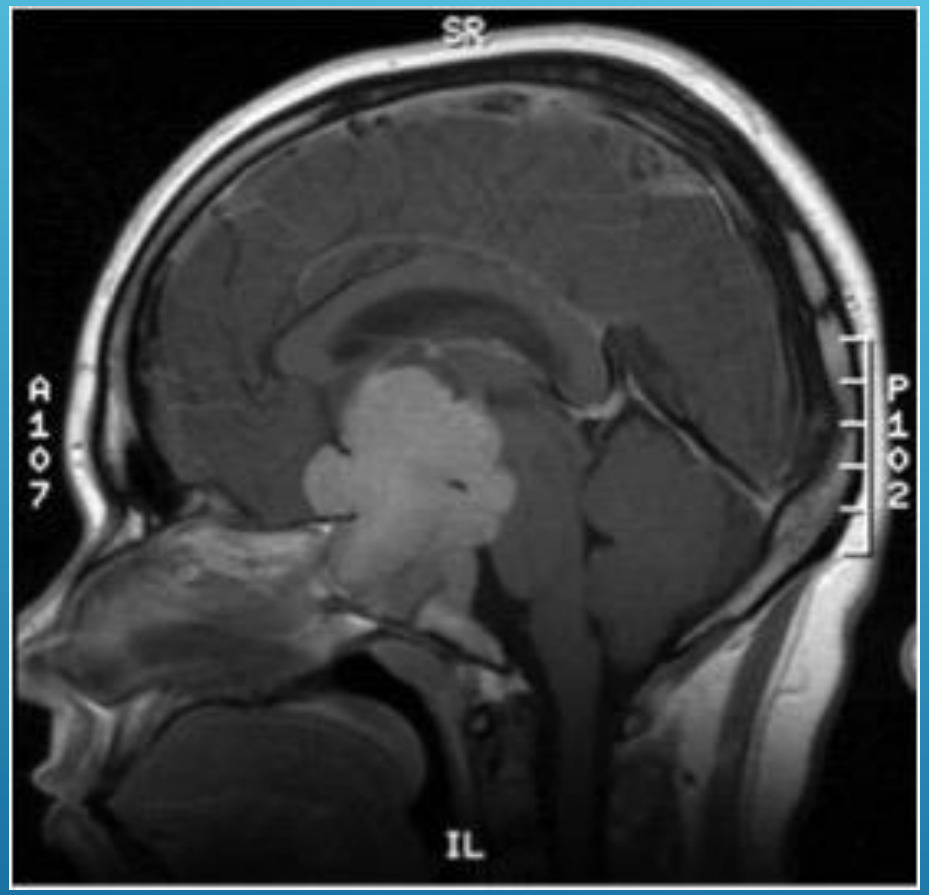
- Bilateral: Think systemic causes
- Unilateral: Think local causes

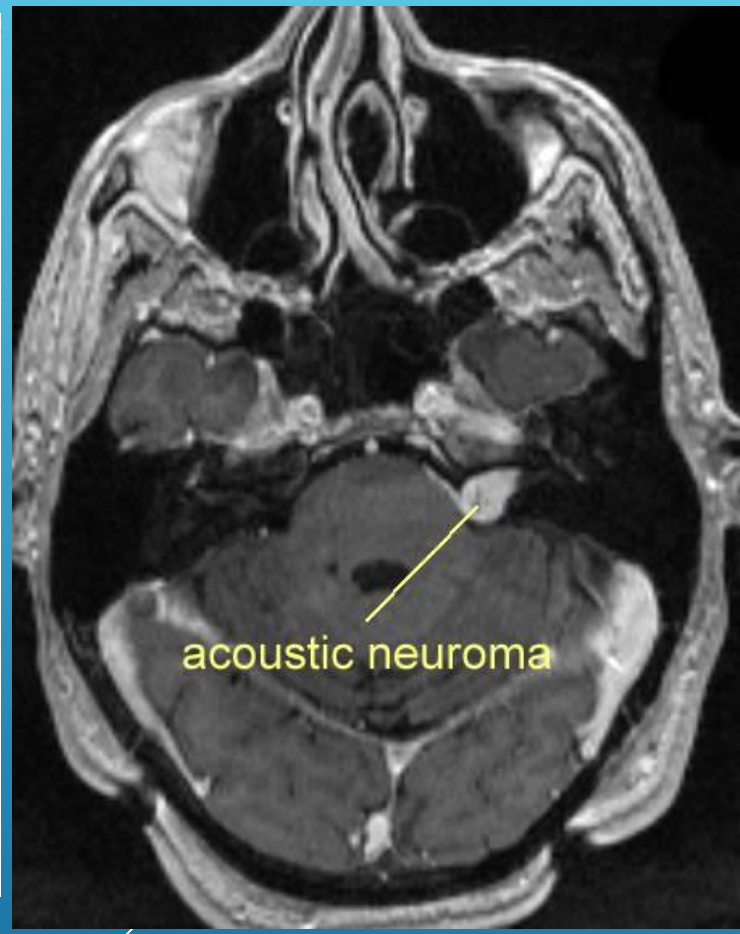




VERTIGO

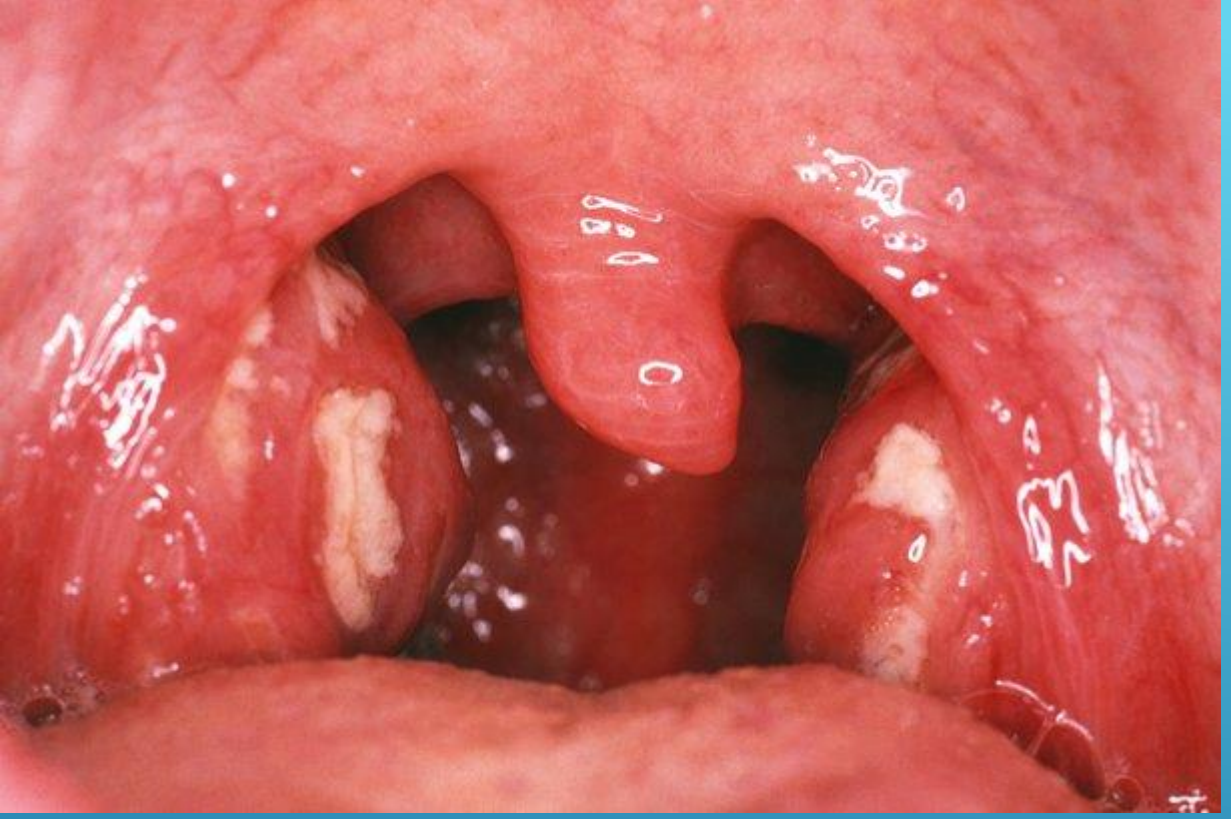
- Central vs. Peripheral
- Duration
- Other symptoms
- Hearing Loss?
- Meclizine

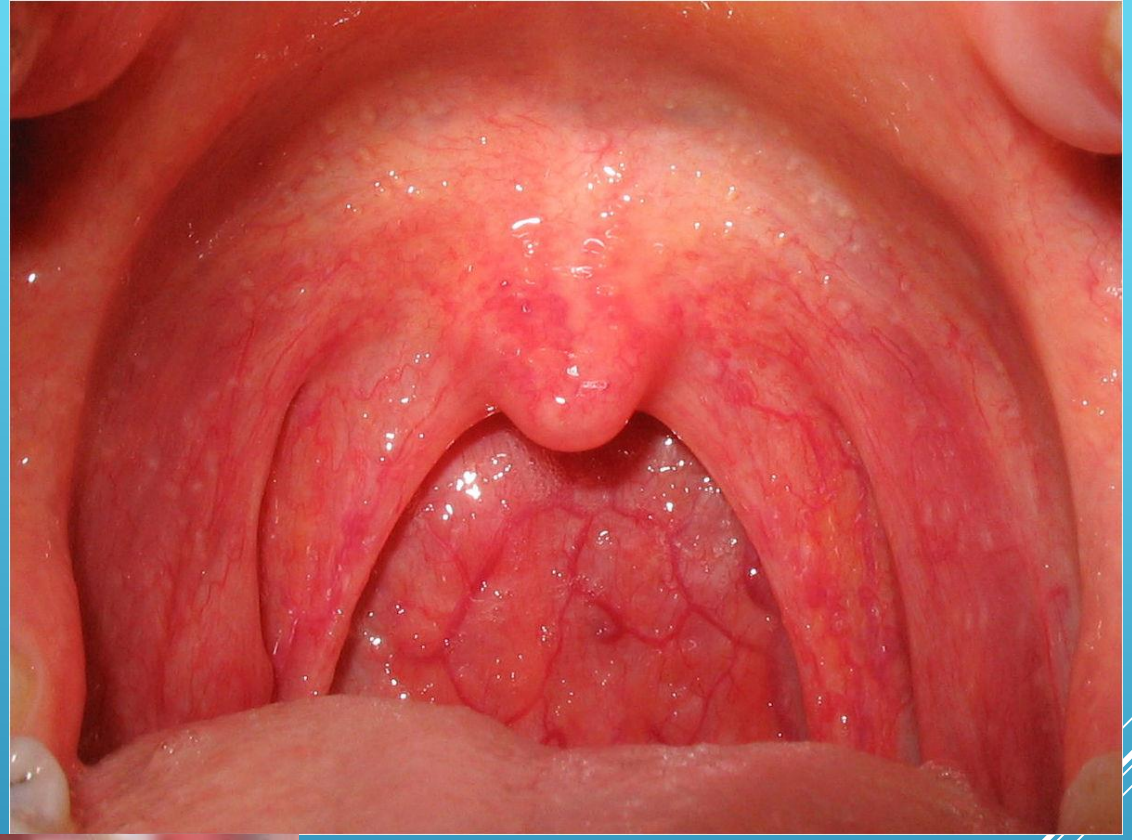


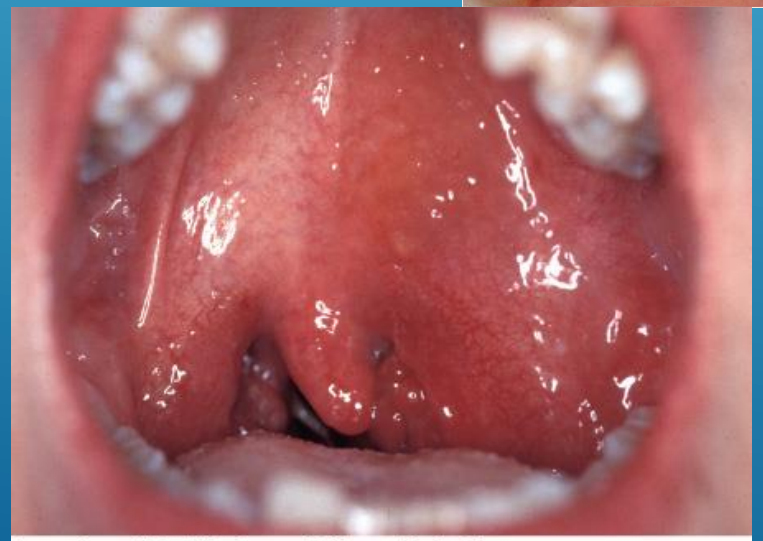


SORE THROAT

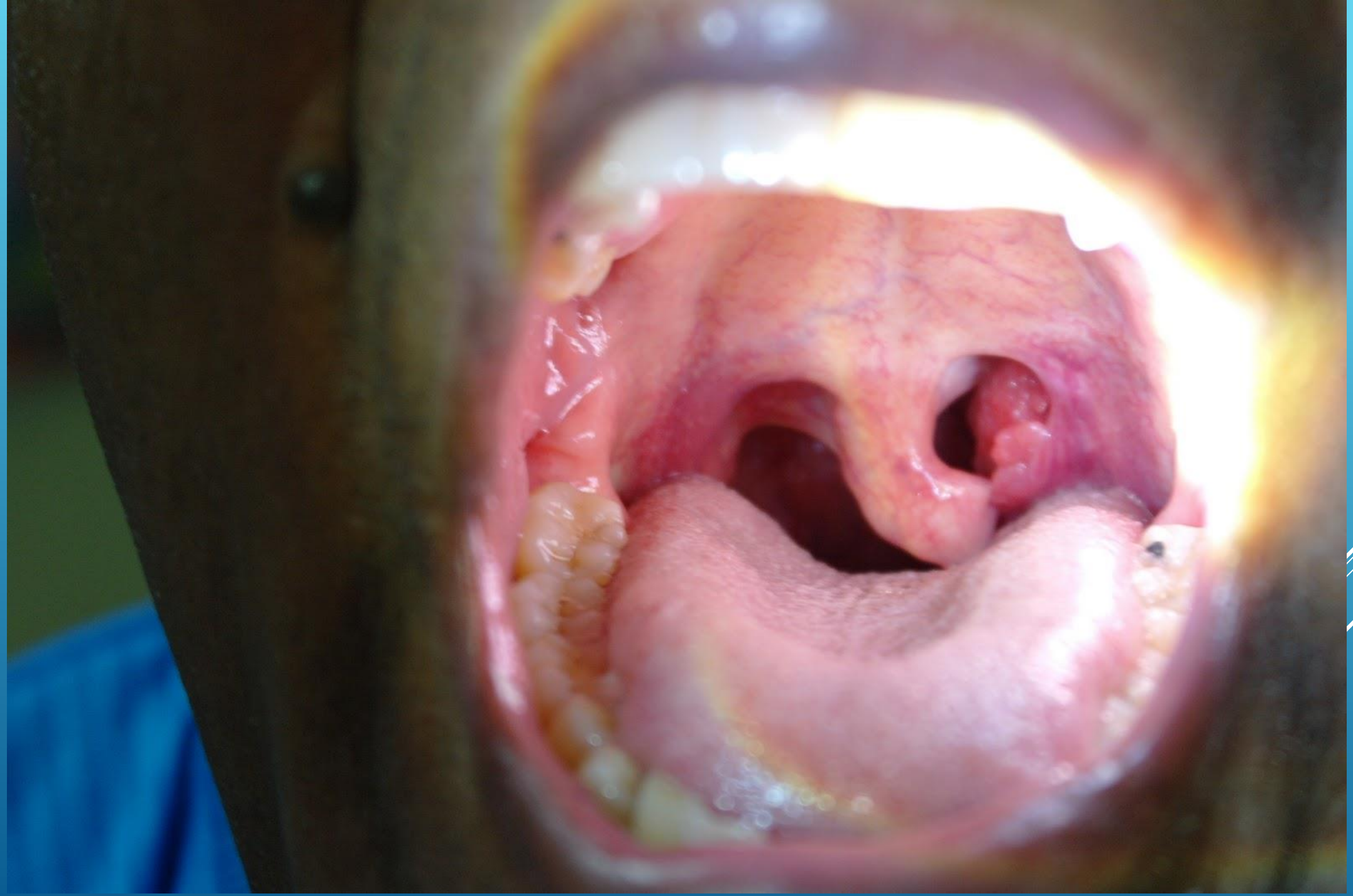
- Duration
- Other symptoms- fever, exudates, exposures, allergies
- Smoker





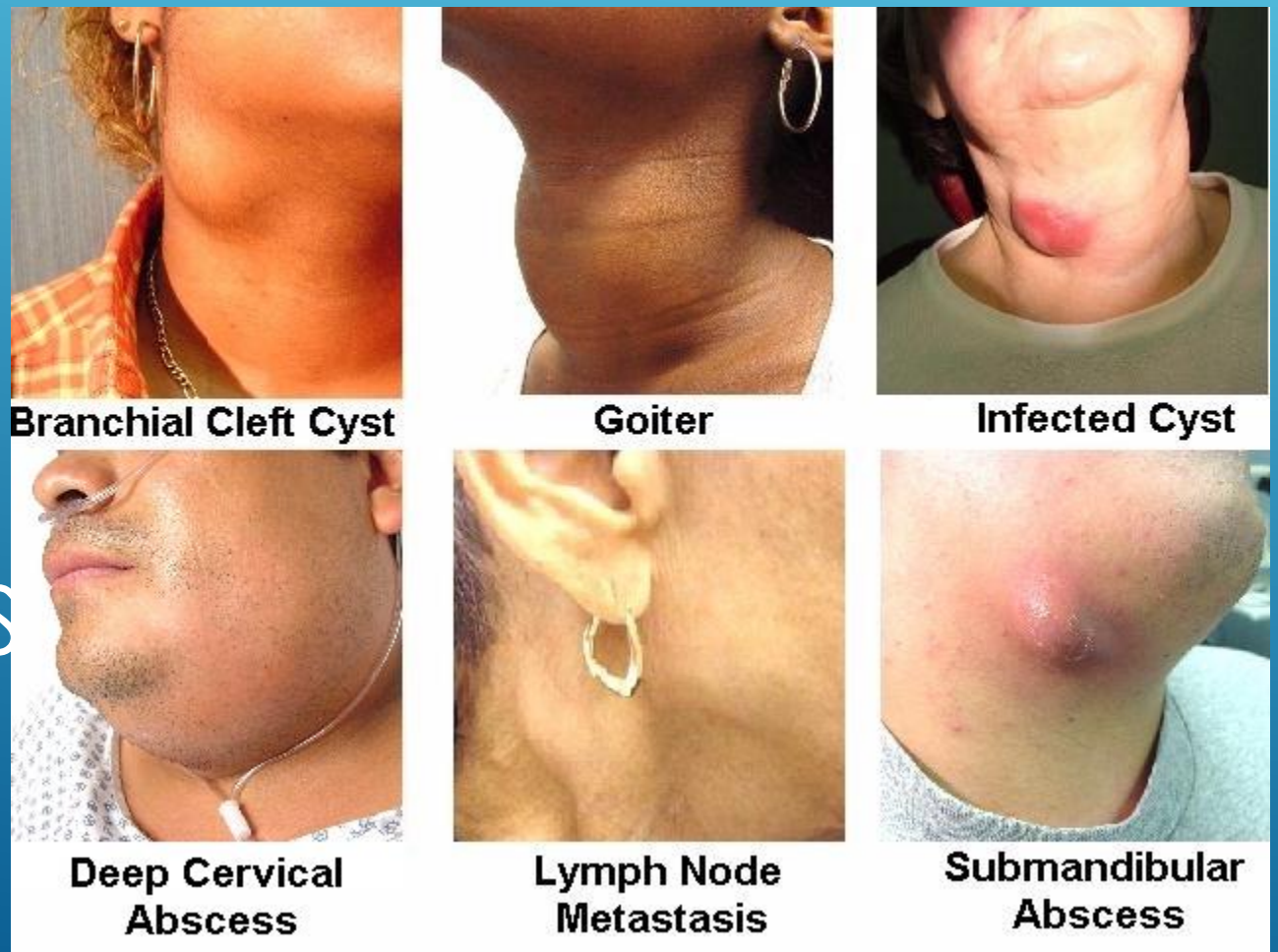


Source: Knoop KJ, Stack LB, Storrow AB, Thurman RJ: *The Atlas of Emergency Medicine, 3rd Edition:* http://www.accessmedicine.com



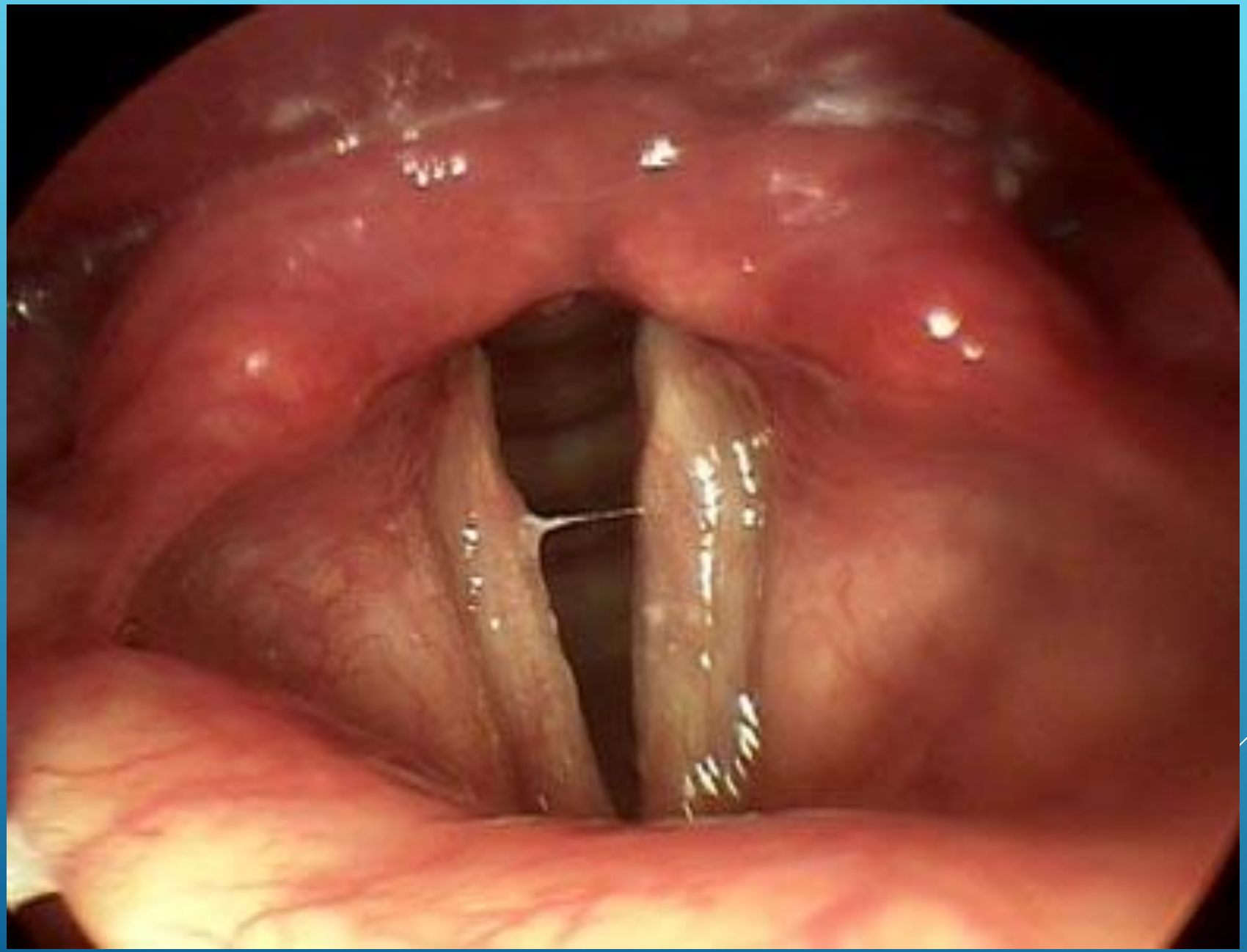
NECK MAS

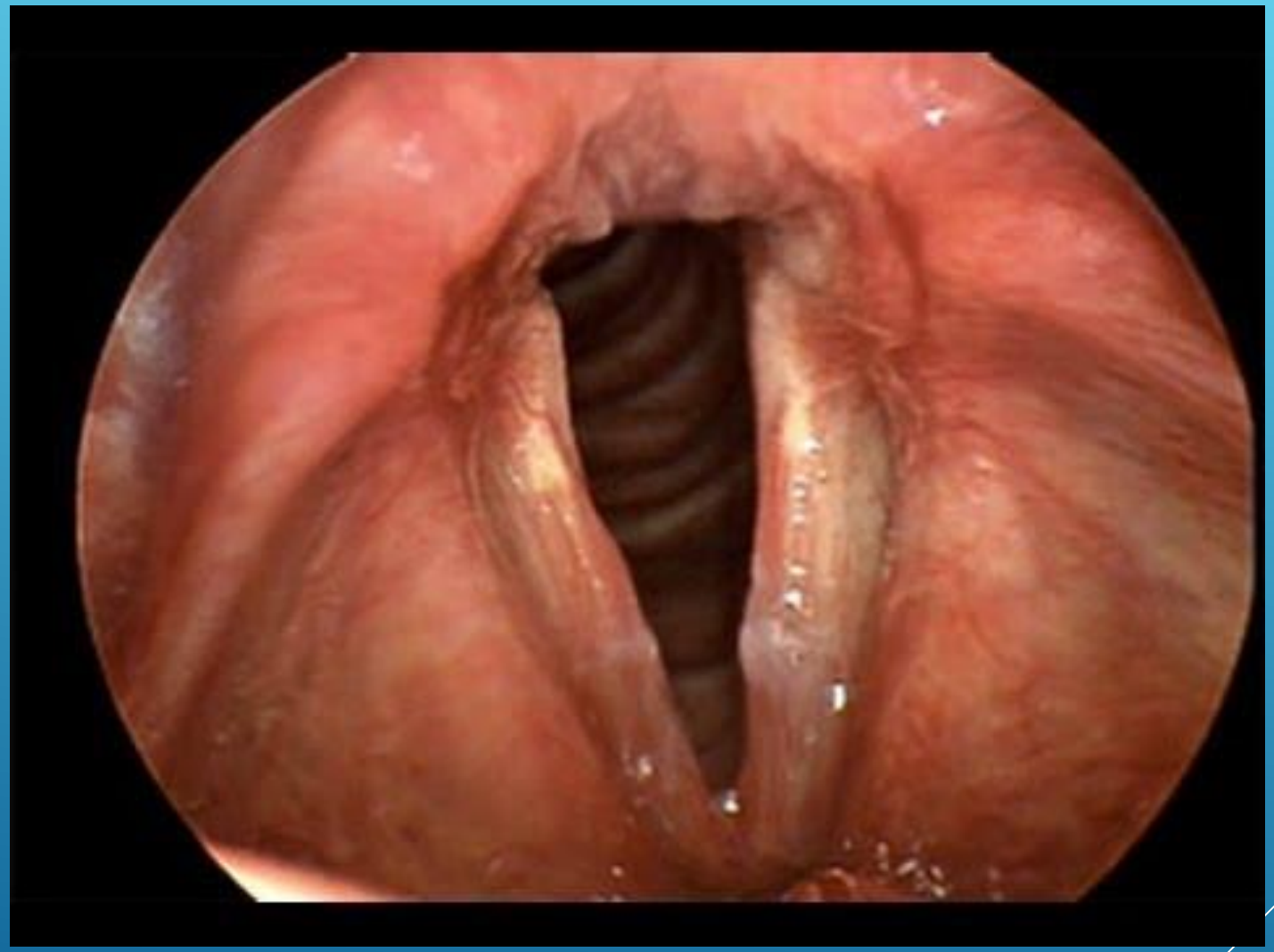
- Central vs Lateral- most important is duration!



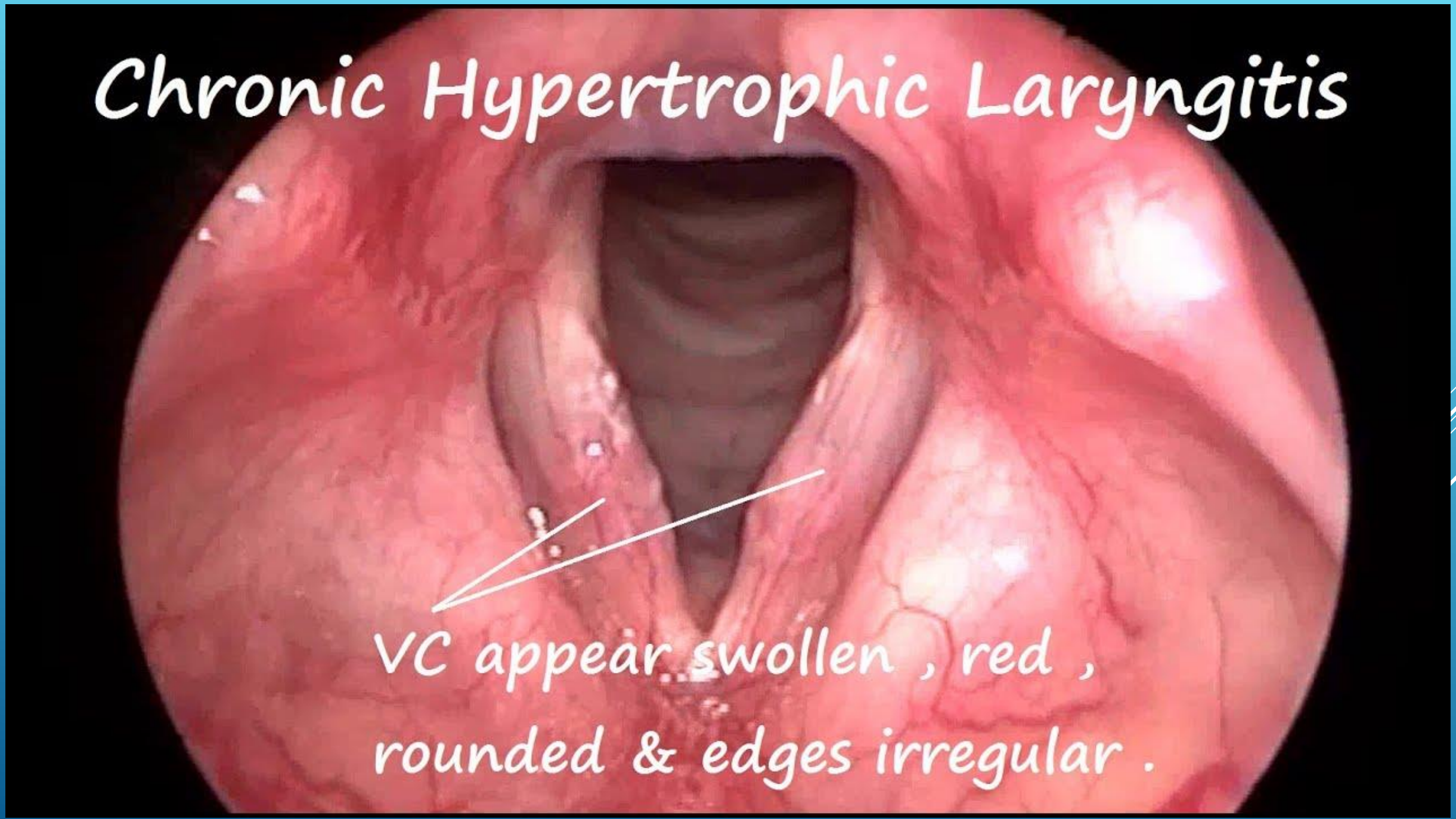
- Smoker
- Duration
- Airway issues
- Eating issues

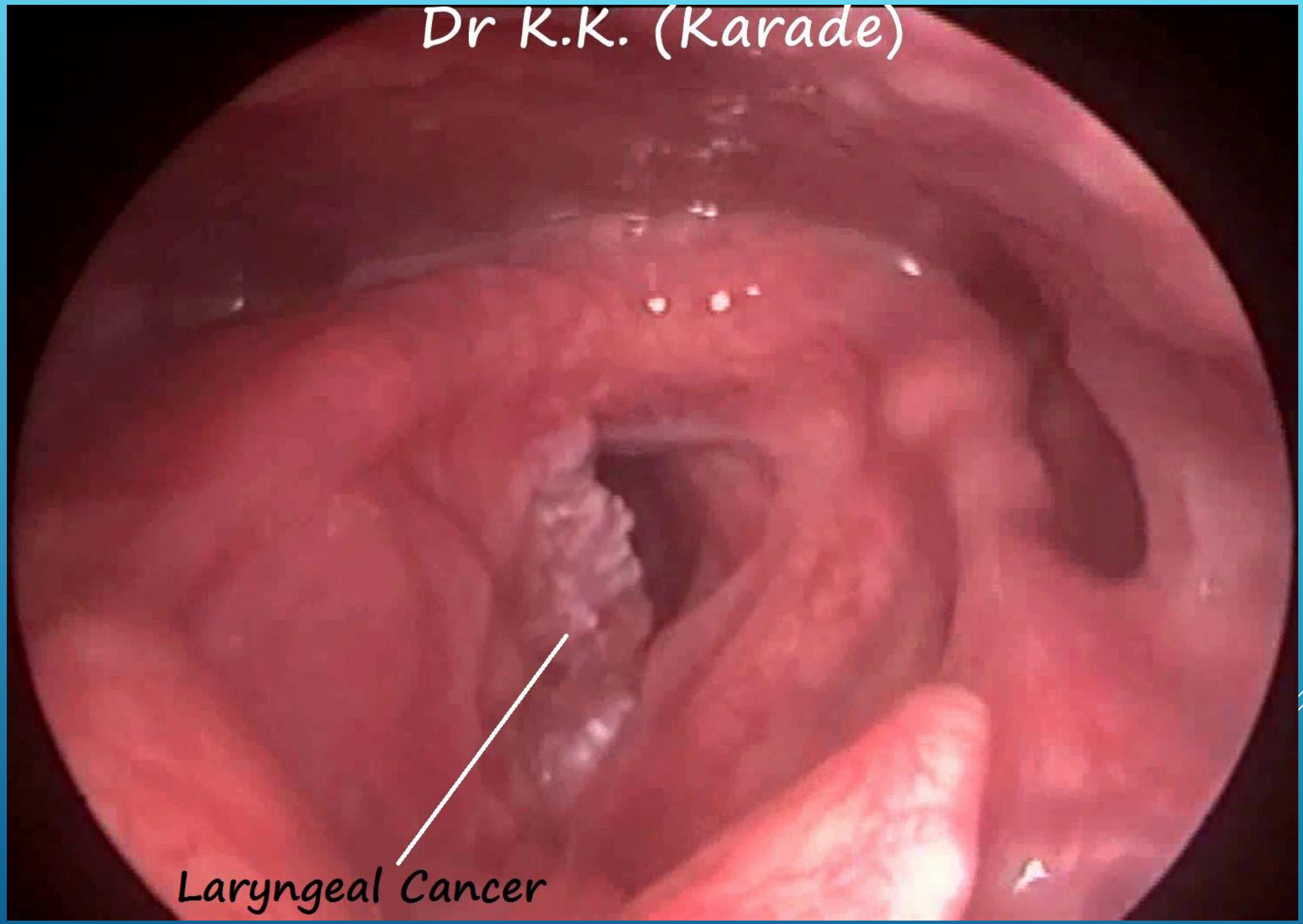
HOARSENESS





Chronic Hypertrophic Laryngitis




Dr K.K. (Karade)
Laryngeal Cancer

- Which is an indication to perform tympanostomy tube placement?
- A: First uncomplicated ear infection
- B: Multiple uncomplicated ear infections
- C: Chronic Otitis Media with Effusion and hearing difficulties
- D: tympanic membrane perforation

- Tonsillectomy Should be considered in the following scenario?
- A: Sleep Disordered Breathing.
- B: Three Episodes of uncomplicated pharyngitis.
- C: Moderate to severe allergic rhinitis
- D: Halitosis

QUESTIONS