Monash Health Referral Guidelines

(Incorporating Statewide Referral Criteria)

ENT

EXCLUSIONS

Services not offered by Monash Health

CONDITIONS

Ear

Bilateral or asymmetrical hearing loss
Discharging ear
Tinnitus
Vertigo (ENT)

Throat

Dysphagia (ENT)
Hoarse Voice (Dysphonia)
Recurrent Tonsillitis
Obstructive Sleep Apnoea (Adult)

Nose

Acute Nasal Fracture
Rhinosinusitis

ENT Head & Neck Oncology

Neck Mass or Lumps
Salivary Gland Disorder or Mass
Thyroid Mass

ADDITIONAL CONDITIONS

See **ENT Conditions Additional to Statewide Referral Criteria**

Additional Conditions:

Ear:

Recurrent Acute Otitis Media
Middle Ear Effusion (Glue Ear)
Ear Drum Perforation
Chronic Ear Disease

Throat:

Paediatric Sleep Disturbance
Obstructive Sleep Apnoea (Paediatric)

Nose:

Nasal Congestion/Obstruction
Recurrent Epistaxis
Nasal Reconstruction/Rhinoplasty

Other:

Facial Palsy

See also:

Vertigo (Neurology)
Dysphagia (Gastroenterology)

PRIORITY

All referrals received are triaged by **Monash Health clinicians** to determine **urgency of referral.**

EMERGENCY

For emergency cases please do any of the following:
- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

Head of unit: Mr Adnan Safdar

Program Director: Mr Alan Saunder

Last updated: 19/12/2019

MonashHealth

Monash Health Referral Guidelines

(Incorporating Statewide Referral Criteria)

ENT

REFERRAL

How to refer to Monash Health

Find up-to-date information about how to send a referral to Monash Health on the eReferrals page on our website.

CONTACT US

Medical practitioners

To discuss complex & urgent referrals contact: the on-call ENT Registrar on 9594 6666

General enquiries

Phone: 1300 342 273

EAR

BILATERAL OR ASYMMETRICAL HEARING LOSS

Criteria for Referral to Public Hospital Specialist Clinic Services

- Asymmetrical hearing loss with significant impact on the patient
- Sensorineural hearing loss confirmed by diagnostic audiology assessment
- Symmetrical hearing loss caused by ototoxic medicine(s)

Information to be included in Referral

Information that **must** be provided:

- Results of diagnostic audiology assessment

Provide if available:

- Description of hearing loss or change in hearing

Additional Comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Asymmetrical sensorineural hearing loss pathway

Referral to a public hospital is not appropriate for

- Symmetrical gradual onset hearing loss
- Symmetrical age-related hearing loss
- Patients with a normal audiogram

Initial GP Work Up

- Sudden sensorineural hearing loss (SSNHL):defined as sensorineural hearing loss of at least 30dB over three frequencies of less than three days duration
- Audiogram

Management Options for GP

- If sensorineural hearing loss confirmed on audiogram (or suspected on tuning fork tests, if audiogram not available) and otological examination confirms normal tympanic membranes, oral steroids if not contraindicated at a dose of 1mg/kg for 7 days (immediate treatment)

WHEN TO REFER?

Emergency

- Sudden onset hearing loss in the absence of clear aetiology
- Sudden hearing loss due to trauma or vascular event
- Sudden, profound hearing loss

Routine

All patients with sudden hearing loss should be referred for proper workup including an MRI scan of the cerebellopontine angle

BACK

EAR

DISCHARGING EAR

Criteria for Referral to Public Hospital Specialist Clinic Services

- Non-painful discharging ear for longer than two weeks that fails to settle with treatment
- Otorrhea
- Cholesteatoma

Information to be included in Referral

Information that **must** be provided:

- Microscopy, culture and sensitivity (MCS) ear swab

Provide if available:

- History of smoking
- Excessive alcohol intake

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Ear discharge in adults pathway

Referral to a public hospital is not appropriate for

- Waxy ear discharge

WHEN TO REFER?

Emergency

Immediately contact the ENT Registrar to arrange urgent ENT assessment for:

- Ear discharge with moderate to severe persistent ear pain, persistent headache, cranial nerve neuropathy or facial palsy
- Malignant otitis externa
- Suspected skull base osteomyelitis
- Cellulitis of the pinna
- Suspected mastoiditis
- Osteitis ear

BACK

EAR

TINNITUS

WHEN TO REFER?

Criteria for Referral to Public Hospital Specialist Clinic Services

- Recent onset of unilateral tinnitus
- Pulsatile tinnitus present for more than six months

Urgent

Asymmetrical sensorineural deafness, vertigo

Information to be included in Referral

Information that **must** be provided:

- Results of diagnostic audiology assessment

Provide if available:
Not applicable

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Tinnitus pathway

Referral to a public hospital is not appropriate for

- Patients with a normal audiogram

Initial GP Work Up

- Audiogram

Management Options for GP

- Refer to Australian Hearing Services for options eg: masking hearing aid

BACK

EAR

VERTIGO (ENT)

Criteria for Referral to Public Hospital Specialist Clinic Services

- Vertigo that has not responded to vestibular physiotherapy treatment

Information to be included in Referral

Information that **must** be provided:

- Results of diagnostic vestibular physiotherapy assessment or Epley manoeuvre
- Results of diagnostic audiology assessment
- Onset duration and frequency of vertigo

Provide if available:

Description of any of the following:

- Functional impact of vertigo
- Any associated otological or neurological symptoms
- Any previous diagnosis of vertigo (attach correspondence)
- Any treatments (medication or other) previously tried, duration of trial and effect
- Any previous investigations or imaging results
- Hearing or balance symptoms
- Past history of middle ear disease or surgery

History of any of the following:

- Cardiovascular problems
- Neck problems
- Neurological
- Auto immune conditions
- Eye problems
- Previous head injury

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Chronic or episodic vertigo and vertigo with other neurological symptoms should be directed to a neurology service.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Vertigo (dizziness) pathway

Initial GP Work Up

- Audiogram
- Electrocardiogram (cardiac factors)

Management Options for GP

- Dix Hallpike manoeuvre to diagnose BPPV, and Epleys manoeuvre to treat if positive

WHEN TO REFER?

Emergency

Direct to an appropriate emergency department for:

- Sudden onset debilitating vertigo where the patient is unsteady on their feet or unable to walk without assistance
- Barotrauma with sudden onset vertigo, or symptoms suggestive of stroke or transient ischaemic attacks

Urgent

- Intractable rotatory vertigo resistant to conservative measures. Unilateral hearing loss and tinnitus

THROAT

DYSPHAGIA (ENT)

Criteria for Referral to Public Hospital Specialist Clinic Services

- Oropharyngeal or throat dysphagia with either:
  - Hoarseness
  - Progressive weight loss
  - History of smoking
  - Excessive alcohol intake
- Progressively worsening oropharyngeal or throat dysphagia
- Inability to swallow with drooling or pooling of saliva

Information to be included in Referral

Information that **must** be provided:

- History of symptoms over time
- History of smoking
- History of excessive alcohol intake

Provide if available
Not applicable

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals for oesophageal dysphagia should be directed to a gastroenterology service provided by the health service

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Dysphagia pathway

Initial GP Work Up

- Barium swallow

Management Options for GP

- Referral may be required if there is suspicion of a sinister pathology in a patient with history of smoking and alcohol intake

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Sudden onset of inability to swallow
- Swallowing problems accompanied by difficulty in breathing or stridor
- Difficulty in swallowing caused by a foreign body or solid food

Urgent

Referral may be required if there is dysphagia with suspicion of a sinister pathology and history of weight loss

Routine

Referral may be required if there is a long history of dysphagia

BACK

THROAT

HOARSE VOICE (DYSPHONIA)

WHEN TO REFER?

Criteria for Referral to Public Hospital Specialist Clinic Services

- Persistent hoarseness, or change in voice quality, which fails to resolve in four weeks
- Recurrent episodes of hoarseness, or altered voice, in patients with no other risk factors for malignancy

Emergency

Direct to an appropriate emergency department for:

- Hoarse voice associated with difficulty in breathing or stridor
- Hoarse voice associated with acute neck or laryngeal trauma

Information to be included in Referral

Information that **must** be provided:

- Duration of symptoms

Provide if available:

- If patient is a professional voice user
- Any of the following:
  - History of smoking
  - Excessive alcohol intake
  - Recent intubation
  - Recent cardiac or thyroid surgery

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Hoarse voice (dysphonia)

Referral to a public hospital is not appropriate for

Not applicable

Initial GP Work Up

- Nil required

Management Options for GP

- Removal of irritants such as smoking, allergies, etc.
- Removal of voice abuse and advice regarding vocal hygiene.
- Manage environmental factors:
  - Discuss and manage basic sleep hygiene issues
  - Discuss effects of smoking and alcohol intake

BACK

THROAT

RECURRENT TONSILLITIS

Criteria for Referral to Public Hospital Specialist Clinic Services

- Chronic or recurrent infection with fever or malaise and decreased oral intake and any of the following:
  - four or more episodes in the last 12 months
  - six or more episodes in the last 24 months
  - tonsillar concretions with halitosis
  - absent from work or studies for four or more weeks in a year
- Suspicious unilateral tonsillar solid mass with or without ear pain

Information to be included in Referral

Information that **must** be provided:

- History of tonsillitis episodes and response to treatment
- If the patient is taking anticoagulant, or any other medicine that may reduce coagulation, or if there is a family history of coagulation disorder

Provide if available:
Not applicable

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Tonsillitis and sore throat in adults pathway

Referral to a public hospital is not appropriate for

- If the patient is not willing to have surgical treatment
- Halitosis without other symptoms

Initial GP Work Up

- N/A

Management Options for GP

- Manage acute episodes with oral penicillin V (avoid amoxicillin/ampicillin)

WHEN TO REFER?

Emergency

Direct to an appropriate emergency department for:

- Abscess or haematoma (e.g. peritonsillar abscess or quinsy)
- Acute tonsillitis with:
  - Difficulty in breathing
  - Unable to tolerate oral intake
  - Uncontrolled fever
- Post-operative tonsillar haemorrhage

Routine

- When the frequency of attacks are causing significant educational/social constraints that all involved want to consider surgery
- 2 prior episodes of quinsy in someone with no history of recurrent tonsillitis OR 1 quinsy if there is history

BACK

THROAT

OBSTRUCTIVE SLEEP APNOEA (ADULT)

Criteria for Referral to Public Hospital Specialist Clinic Services

- Obstructive sleep apnoea with:
  - Nasal obstruction
  - Macroglossia

Information to be included in Referral

Information that **must** be provided:

- History of symptoms over time and burden of symptoms, sleep quality (especially the story from partner), waking during the night and level of tiredness (including Epworth Sleepiness Scale)
- Patient's weight
- If the patient is taking an antidepressant medicine

Provide if available:

- Recent polysomnography results

Additional comments

The Summary and referral information lists the information that should be included in a referral request. Referrals for other forms of obstructive sleep apnoea should be directed to a multidisciplinary sleep clinic or respiratory service.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Obstructive Sleep Apnoea (OSA) in adults pathway

Referral to a public hospital is not appropriate for

Not applicable

Initial GP Work Up

- Presentation: Witnessed breath-holding/choking episodes during sleep
- Unrefreshing/restless sleep
- Referral to sleep physician for evaluation, PSG and consideration of CPAP
- Bariatric referral if BMI>35

Management Options for GP

Medically manage nasal obstruction:

- Long-term intranasal steroids (mometasone) if no contraindications
- Manage allergies
- Weight loss

Manage environmental factors:

- Discuss and manage basic sleep hygiene issues
- Discuss effects of smoking and alcohol intake
- Counsel regarding safety for work and driving while untreated

WHEN TO REFER?

Emergency

Immediately contact the ENT Registrar to arrange an urgent ENT assessment for:

- Rapid progression of obstructive sleep apnoea

BACK

NOSE

ACUTE NASAL FRACTURE

Criteria for Referral to Public Hospital Specialist Clinic Services

Not applicable

Information to be included in Referral

Information that **must** be provided:
Not applicable

Provide if available
Not applicable

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

As patients with an acute nasal fracture should be referred to an appropriate emergency department for ENT assessment; public hospital specialist clinics should not receive any referrals for this presenting problem

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Nasal fracture pathway

Referral to a public hospital is not appropriate for

The nose is not bent, or there is no new deformity, or there is no obstruction

WHEN TO REFER?

Emergency

Direct to an appropriate emergency department for an ENT assessment

- Acute nasal fracture with septal haematoma
- A new injury where the nose is bent, there is a compound fracture or epistaxis that fails to settle

Please refer within a week of the injury and indicate the date and mechanism of the injury

BACK

NOSE

RHINOSINUSITIS

Criteria for Referral to Public Hospital Specialist Clinic Services

- New and persistent unilateral nasal obstruction present for more than four weeks
- Rhinosinusitis that has not responded to three months of intranasal steroid and nasal lavage treatment
- Should have symptoms of nasal obstruction and discharge

Information to be included in Referral

Information that **must** be provided:

- Presence of epistaxis
- Details of previous medical management including the course of treatment (e.g. intranasal steroid, nasal lavage or antibiotics) and outcome of treatment

Provide if available:
Not applicable

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Rhinosinusitis pathway

Referral to a public hospital is not appropriate for

- Patients with headaches who have a normal CT scan which has been performed when the patient has symptoms
- Patients who have not had three months of intranasal steroid and nasal lavage treatment

(Continued over page)

WHEN TO REFER?

Emergency

Direct to an appropriate emergency department for:

- Complicated sinus disease with:
  - Orbital and/or neurological signs
  - Severe systemic symptoms
  - Periorbital oedema or erythema
  - Altered visual acuity, diplopia, or reduced eye movement

Urgent

- Complicated sinus disease (extrasinus extension, suggestion of fungal disease)

Routine

- Failed maximal medical management with CT evidence of sinus disease

BACK

NOSE

RHINOSINUSITIS (continued)

Initial GP Work Up

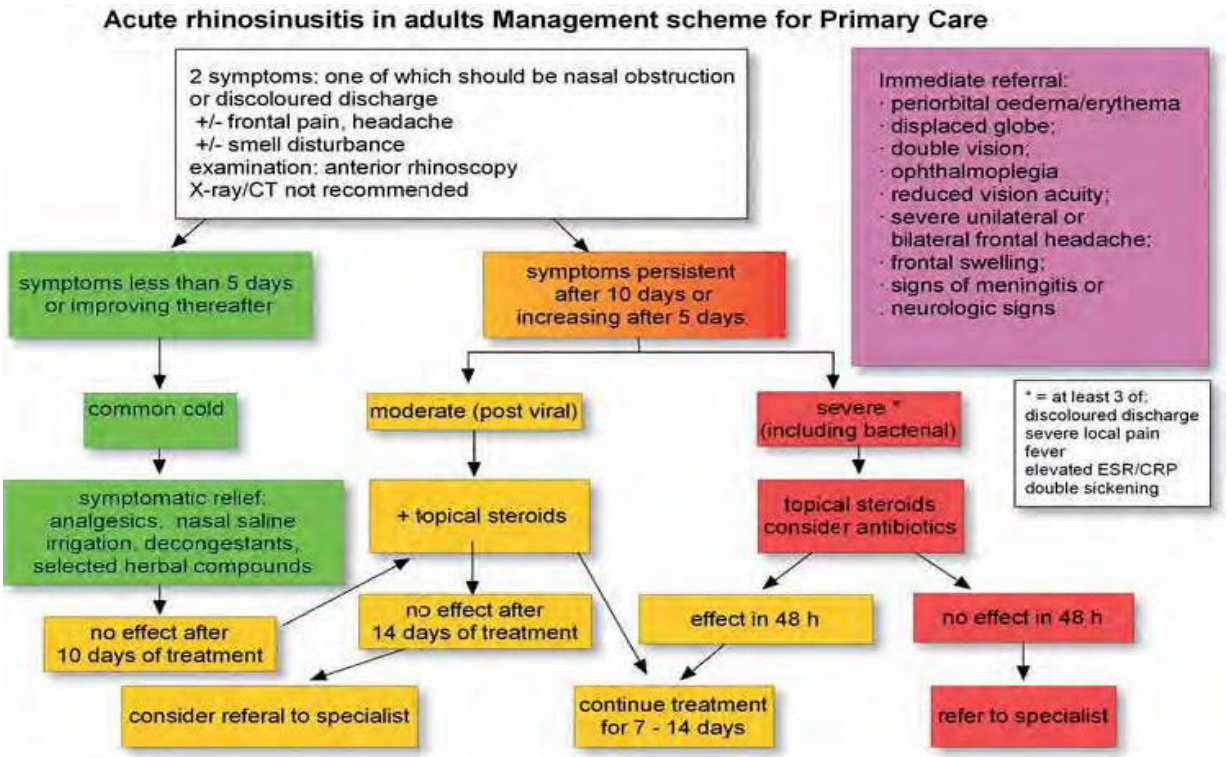
- Establish disease entity: acute (ARS) – symptoms for <12 weeks (and recurrent with >3 episodes/yr) versus chronic (CRS) – persistent symptoms >12 weeks
- Initiate medical management
- Needs recent CT confirming sinomucosal disease (AFTER full course of medical Mx); may be normal in cases of recurrent ARS
- Manage co-existing allergies

Management Options for GP

- Treat any acute bacterial infection appropriately (10 day course of Augmentin duo **forte)**

Medical management of CRS – 3 months of:

- I/N saline rinse/irrigation (not spray) BD-TDS
- I/N mometasone (BD for 2 weeks, then OD thereafter)
- 5 days only of BD oxymetazoline at start of course
- If symptoms persist after treatment – CT sinuses (no point in scanning before medical management)
- If rhinorrhea predominant symptom – add either Atrovent spray OR 2nd generation antihistamine
- Manage environmental factors
- Manage any co-existing allergies
- Discuss contribution of smoking
- Discuss role of environmental and household pollutants (wood/coal smoke, incense, perfumes, chlorine)



BACK

ENT HEAD & NECK ONCOLOGY

NECK MASS OR LUMPS

Criteria for Referral to Public Hospital Specialist Clinic Services

- Confirmed head and neck malignancy
- New suspicious solid mass, or cystic neck lumps, present for more than four weeks
- New suspicious solid mass, or cystic neck lumps, in patients with a previous head/neck malignancy
- Sialadenitis
- Presentation, diagnosis, investigation and management of patients with malignancies of the head and neck, oral cavity, throat, nose and sinuses, salivary glands and thyroid.
- Certain benign conditions are also catered for, e.g. thyroid and salivary glands.
- Paediatric head and neck malignancy referrals are also accepted.

Information to be included in Referral

Information that **must** be provided:

- CT scan of the neck, with contrast where appropriate (preferred) or ultrasound

Provide if available

Any of the following:

- History of smoking
- Excessive alcohol intake
- Full blood count
- Fine needle aspiration biopsy

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Neck lumps in adults pathway

Referral to a public hospital is not appropriate for

Not applicable

(Continued over page)

WHEN TO REFER?

Emergency

Direct to an appropriate emergency department for an ENT assessment:

- Sudden or new mass or lump associated with difficulty in breathing or swallowing
- Sialadenitis with difficulty breathing
- Ludwig's angina

Immediately contact the ENT Registrar to arrange an urgent ENT assessment for:

- Acute inflammatory neck mass with redness, pain or increased swelling

Urgent

- Directly to the Head & Neck Clinical Nurse Specialist for all suspected malignancies - T: 9928 8711 or F: 9928 8052.
- Any airway compromise please contact the ENT registrar on call via T: 9594 6666.

BACK

ENT HEAD & NECK ONCOLOGY

NECK MASS OR LUMPS (Continued)

Initial GP Work Up

- If a CT scan is done please include the chest.
- For neck lumps and thyroid an ultrasound +- CT scan.
- Other investigations will be tailored to the patient's condition.

Management Options for GP

The clinic provides the latest and up to date multidisciplinary management of these conditions in a weekly multidisciplinary team meeting. Clinicians in attendance are from the specialties of ENT, Plastic Surgery, Oral and Maxillofacial Surgery, Dental, Radiotherapy, Palliative Care, Chemotherapy, Radiology, Pathology and Speech Pathology.

BACK

ENT HEAD & NECK ONCOLOGY

SALIVARY GLAND DISORDER OR MASS

Criteria for Referral to Public Hospital Specialist Clinic Services

- Confirmed or suspected tumour or solid mass in the salivary gland
- Symptomatic salivary stones with recurrent symptoms unresponsive to treatment
- Presentation, diagnosis, investigation and management of patients with malignancies of the head and neck, oral cavity, throat, nose and sinuses, salivary glands and thyroid.
- Certain benign conditions are also catered for, e.g. thyroid and salivary glands.
- Paediatric head and neck malignancy referrals are also accepted.

Information to be included in Referral

Information that **must** be provided:

- History of symptoms
- Location of site(s) of mass
- History of skin cancers removed
- History of smoking

Provide if available:

- Ultrasound results
- CT scan results

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals for patients with mumps or patients with HIV with bilateral symptoms should be directed to an infectious disease service.

Referrals for patients with Sjogren's syndrome should be directed to a rheumatology service.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Salivary gland disorders pathway

Referral to a public hospital is not appropriate for

Not applicable

(Continued over page)

WHEN TO REFER?

Emergency

Direct to an appropriate emergency department for:

Salivary abscess associated with:

- Swelling in the neck
- Difficulty in breathing

Immediately contact the ENT Registrar to arrange an urgent ENT assessment for:

- Acute salivary gland inflammation unresponsive to treatment
- Sialadenitis in immunocompromised patients, or facial nerve palsy

Urgent

- Directly to the Head & Neck Clinical Nurse Specialist for all suspected malignancies - T: 9928 8711 or F: 9928 8052.
- Any airway compromise please contact the ENT registrar on call via T: 9594 6666.

BACK

ENT HEAD & NECK ONCOLOGY

SALIVARY GLAND DISORDER OR MASS (Continued)

Initial GP Work Up

- None required if there is clinical concern of malignancy
- If a CT scan is done please include the chest.
- For neck lumps and thyroid an ultrasound +- CT scan.
- Other investigations will be tailored to the patient's condition.

Management Options for GP

The clinic provides the latest and up to date multidisciplinary management of these conditions in a weekly multidisciplinary team meeting. Clinicians in attendance are from the specialties of ENT, Plastic Surgery, Oral and Maxillofacial Surgery, Dental, Radiotherapy, Palliative Care, Chemotherapy, Radiology, Pathology and Speech Pathology.

BACK

ENT HEAD & NECK ONCOLOGY

THYROID MASS

WHEN TO REFER?

Criteria for Referral to Public Hospital Specialist Clinic Services

- Suspected or confirmed malignancy
- Compressive symptoms:
  - Changing voice
  - Difficulty in breathing
  - Dysphagia
  - Suspicious dominant nodules or compressive neck nodes
- Generalised thyroid enlargement without compressive symptoms
- Recurrent thyroid cysts
- An increase in the size of previously identified benign thyroid lumps >1cm in diameter
- Presentation, diagnosis, investigation and management of patients with malignancies of the head and neck, oral cavity, throat, nose and sinuses, salivary glands and thyroid.
- Certain benign conditions are also catered for, e.g. thyroid and salivary glands.
- Paediatric head and neck malignancy referrals are also accepted.

Information to be included in Referral

Information that **must** be provided:

- Ultrasound with, or without, fine needle aspiration results
- Thyroid stimulating hormone (TSH) and free thyroxine (T4) results

Provide if available:

- Not applicable

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals for patients with hyperthyroidism should be directed to an endocrinology service.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Thyroid nodules pathway

Referral to a public hospital is not appropriate for

- Non-bacterial thyroiditis
- Uniform, enlarged gland suggestive of thyroiditis without other symptoms

(Continued over page)

Emergency

Direct to an appropriate emergency department for:

- Thyroid mass with difficulty in breathing or with bleeding from the nodule

Urgent

- Directly to the Head & Neck Clinical Nurse Specialist for all suspected malignancies - T: 9928 8711 or F: 9928 8052.
- Any airway compromise please contact the ENT registrar on call via T: 9594 6666.

BACK

ENT HEAD & NECK ONCOLOGY

THYROID MASS (Continued)

Initial GP Work Up

- If a CT scan is done please include the chest.
- For neck lumps and thyroid an ultrasound +- CT scan.
- Other investigations will be tailored to the patient's condition.

Management Options for GP

The clinic provides the latest and up to date multidisciplinary management of these conditions in a weekly multidisciplinary team meeting. Clinicians in attendance are from the specialties of ENT, Plastic Surgery, Oral and Maxillofacial Surgery, Dental, Radiotherapy, Palliative Care, Chemotherapy, Radiology, Pathology and Speech Pathology.

BACK

Monash Health Referral Guidelines

(Conditions Additional to Statewide Referral Criteria)

ENT

EXCLUSIONS

Services not offered by Monash Health

ADDITIONAL CONDITIONS

Ear

Recurrent Acute Otitis Media
Middle Ear Effusion (Glue Ear)
Ear Drum Perforation
Chronic Ear Disease

Throat

Paediatric Sleep Disturbance
Obstructive Sleep Apnoea (Paediatric)

Nose

Nasal Congestion/Obstruction
Recurrent Epistaxis
Nasal Reconstruction/Rhinoplasty

Other

Facial Palsy

PRIORITY

All referrals received are triaged by **Monash Health clinicians** to determine **urgency of referral.**

EMERGENCY

For emergency cases please do any of the following:
- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

Head of unit: Mr Adnan Safdar

Program Director: Mr Alan Saunder

Last updated: 19/12/2019

EAR

RECURRENT ACUTE OTITIS MEDIA

Initial GP Work Up

- Presentation: Recurrent ear infections associated with URTIs, otalgia, recurrent ear discharge
- MUST have recent audiogram (within preceding 6 months)

Management Options for GP

Treat acute episodes:

- Amoxicillin (45mg/kg) BD for 10 days OR
- Augmentin duo (45mg/kg) BD for 10 days
- Ciprofloxacin HC drops TDS for 3-7 days if otorrhoea

Manage environmental factors:

- Consider adjusting day care attendance (or to smaller day care facility)
- Discuss with parents risk of passive smoke and AOM (RR-1.66)
- Encourage weaning of pacifier after 11 months (RR-1.24)

WHEN TO REFER?

Urgent

- Recurrent ear infections with resulting social/developmental concerns
- Recurrent ear infections with associated otorrhoea
- Child with craniofacial abnormality
- Speech development delay
- Any adult with acute otitis media (need endoscopic examination of nasopharynx)

BACK

MIDDLE EAR EFFUSION (Glue Ear)

Initial GP Work Up

- Presentation: Hearing loss, speech and language delay, balance and coordination problems
- MUST have recent audiogram (within preceding 6 months

Management Options for GP

- May instigate intranasal steroids IF child has associated nasal congestion/rhinorrhoea and if over 2 years, and NO contraindications (e.g. mometasone 5mcg nocte) – no conclusive evidence of benefit
- Manage environmental factors (till definitive surgery)
- Encourage parents and teachers to speak clearly and directly to child
- Encourage parents to notify teacher so as to best position child in class

WHEN TO REFER?

Urgent

- Persistent audiological evidence of effusion longer than 3 months
- Audiological evidence of bilateral effusion with history suggestive of developmental delay in infant
- Audiological evidence of effusion with history suggestive of social/classroom impairment in school aged children

BACK

EAR

EAR DRUM PERFORATION

Initial GP Work Up

- Presentation: Chronic or recurrent ear discharge, hearing loss
- Topical ear medication
- Keep ear dry
- Audiogram

Management Options for GP

- Review after 3 months

WHEN TO REFER?

Urgent

Recurrent episodes of discharging ear, persistent discharge despite treatment, deteriorating hearing, when vertigo exists with acute perforation, persistent perforation after 3 months

BACK

CHRONIC EAR DISEASE

Initial GP Work Up

- Presentation: Chronic ear discharge (for longer than 3 months)
- Audiogram

Management Options for GP

- Ciprofloxacin HC drops tds for 1 week
- Keep ear dry
- No irrigation of ear

WHEN TO REFER?

Urgent

- Discharging ear for longer than 3 months, failure to settle with topical medication, otalgia, headaches, vertigo, hearing loss
- Complications i.e. meningitis, facial palsy, vertigo

BACK

THROAT

PAEDIATRIC SPEECH DISTURBANCE

WHEN TO REFER?

Initial GP Work Up

- Presentation: Poor speech consistent with age of the child
- Audiogram
- Speech therapist assessment

Management Options for GP

- If audiogram normal, speech therapy input
- If audiogram abnormal manage otitis media with effusion as above

Routine

If above measures fail to show any improvement in speech and suspicion of sensorineural hearing loss on audiogram

BACK

OBSTRUCTIVE SLEEP APNOEA (PAEDIATRIC)

WHEN TO REFER?

Initial GP Work Up

- Presentation: Witnessed breath-holding/choking episodes during sleep
- Unrefreshing/restless sleep
- Behavioural/concentration issues as result
- If snoring alone but not fitting above criteria of recurring episodes of infection – referral to respiratory unit for sleep study

Management Options for GP

- Manage allergy/nasal congestion (nasal saline spray +/- intranasal steroids if not contraindicated)
- Manage environmental factors
- Discuss with parents risks of passive smoke exposure

Urgent

- Co-existing craniofacial abnormality
- Snoring with obvious obstructive features (apnoea/choking/breath-holding)
- Parents adamant they want surgical management and physical examination evidence of large tonsils (Brodsky scale)

BACK

NOSE

NASAL CONGESTION / OBSTRUCTION

WHEN TO REFER?

Routine
- Once failed adequate medical management
- Post traumatic where the patient has decided they want surgical management

Initial GP Work Up
- Presentation: Blocked nose
- If solely for obstruction – no workup necessary

Management Options for GP
Medical management with 2 month course of:
- 5 days only of BD oxymetazoline at start of course
- I/N mometasone (BD for 2 weeks, then OD thereafter)
- BD-TDS saline rinse/irrigation (not spray)

Management of environmental factors:
- Manage any co-existing allergies
- Discuss contribution of smoking
- Discuss role of environmental and household pollutants (wood/coal smoke, incense, perfumes, chlorine)

BACK

RECURRENT EPISTAXIS

WHEN TO REFER?

Routine
Once failed adequate medical management

Initial GP Work Up
- Presentation: Recurrent nose bleeds
- Rule out any coagulation disorder
- Rule out any nasal masses or foreign body

Management Options for GP
- Avoidance of precipitating factors such as nose picking
- Topical ointment BD for 1 week
- If bleeding heavy referral to emergency department may be necessary
- Cautery with silver nitrate

BACK

NOSE

NASAL RECONSTRUCTION / RHINOPLASTY, OBSTRUCTION

Initial GP Work Up

- Presentation: Nasal obstruction with external nasal deformity
- If solely obstruction then no workup necessary

Management Options for GP

Medical management with 2 month course of:

- 5 days only of BD oxymetazoline at start of course
- I/N mometasone (BD for 2 weeks, then OD thereafter)
- BD-TDS saline rinse/irrigation (not spray)

Management of environmental factors:

- Manage any co-existing allergies
- Discuss contribution of smoking
- Discuss role of environmental and household pollutants (wood/coal smoke, incense, perfumes, chlorine

WHEN TO REFER?

Routine

- Once failed adequate medical management
- Post traumatic where the patient has decided they want surgical management

BACK

OTHER

FACIAL PALSY

Initial GP Work Up

- Presentation: Lower motor neurone facial palsy
- Examine ear and parotid region

Management Options for GP

- If Bell's palsy suspected - treat immediately with oral steroids if not contraindicated (1mg/kg for 7 days). Note caution in elderly patient. Patient needs to be counselled regarding side effects. Oral anti-virals may also be used if suspicion of Ramsay-Hunt syndrome with vesicles in ear canal/on soft palate.

WHEN TO REFER?

Routine

- Associated hearing loss or other suspected cranial nerve involvement. Failure of improvement in facial weakness after 3 weeks despite above measures

BACK