



ENT and Facial Problems

One in a series of curriculum statements produced by the Royal College of General Practitioners:

- 1 Being a General Practitioner**
- 2 The General Practice Consultation**
- 3 Personal and Professional Responsibilities**
 - 3.1 Clinical Governance
 - 3.2 Patient Safety
 - 3.3 Clinical Ethics and Values-Based Practice
 - 3.4 Promoting Equality and Valuing Diversity
 - 3.5 Evidence-Based Practice
 - 3.6 Research and Academic Activity
 - 3.7 Teaching, Mentoring and Clinical Supervision
- 4 Management**
 - 4.1 Management in Primary Care
 - 4.2 Information Management and Technology
- 5 Healthy People: promoting health and preventing disease**
- 6 Genetics in Primary Care**
- 7 Care of Acutely Ill People**
- 8 Care of Children and Young People**
- 9 Care of Older Adults**
- 10 Gender-Specific Health Issues**
 - 10.1 Women's Health
 - 10.2 Men's Health
- 11 Sexual Health**
- 12 Care of People with Cancer & Palliative Care**
- 13 Care of People with Mental Health Problems**
- 14 Care of People with Learning Disabilities**
- 15 Clinical Management**
 - 15.1 Cardiovascular Problems
 - 15.2 Digestive Problems
 - 15.3 Drug and Alcohol Problems
 - 15.4 ENT and Facial Problems
 - 15.5 Eye Problems
 - 15.6 Metabolic Problems
 - 15.7 Neurological Problems
 - 15.8 Respiratory Problems
 - 15.9 Rheumatology and Conditions of the Musculoskeletal System (including Trauma)
 - 15.10 Skin Problems

Contents

Acknowledgements 5

Key messages 5

Introduction 6

Rationale for this curriculum statement 6

UK health priorities 6

Learning Outcomes 8

Primary care management 8

The knowledge base 8

Person-centred care 9

Specific problem-solving skills 9

A comprehensive approach 9

Community orientation 10

A holistic approach 10

Contextual aspects 10

Attitudinal aspects 10

Scientific aspects 10

Psychomotor skills 10

Further Reading 11

Examples of relevant texts and resources 11

Web resources 11

Promoting Learning about ENT and Facial Problems 13

Work-based learning – in primary care 13

Work-based learning – in secondary care 13

Non-work-based learning 13

Learning with other healthcare professionals 14

Appendix 1 15

Extract from Referral for Suspected Head and Neck Cancer Guideline 15

References 17

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Key messages

- Many ENT symptoms including deafness are common in general practice.
- The Disability Discrimination Act 1995 gives people with disabilities equal and enforceable rights, and access to all areas of life, including health care.
- Guidelines for appropriate management are widely available but not always used.
- Inappropriate referrals to secondary care increase waiting times, consume resources and can be harmful to patients.
- Early detection of head and neck cancer is vital.

Introduction

Rationale for this curriculum statement

ENT conditions are a common reason for visits to a general practitioner (GP):

- In adults, external ear problems, especially wax, are the most common reason for attendance
- Otitis media is the commonest presentation in ages 0–4 years, falling in older children
- Hay fever affects around 1 in 10 people.

Deafness is a very common problem

There are nine million deaf and hard-of-hearing people in the UK, including 688,000 who have severe or profound deafness.¹

Many people don't know how to communicate with deaf and hard-of-hearing people. This lack of understanding about deafness leads to fear and an unwillingness to communicate among the majority of the hearing population. This communication barrier is huge: it restricts opportunity and prevents integration between deaf and hearing people. Nine out of 10 people who are deaf or hard of hearing have been the subject of abuse from people they have only just met because of their condition.

Deafness and the law: the Disability Discrimination Act 1995

The Disability Discrimination Act (DDA) aims to stop discrimination against people with disabilities. It gives people with disabilities equal and enforceable rights, and access to all areas of life, including health care. The DDA says that service providers are not allowed to treat disabled people less favourably because of their disability. This includes GPs and their teams, health centres, clinics, hospitals, etc.

The DDA means that the GP also has to make 'reasonable adjustments' if, without them, it would be 'impossible or unreasonably difficult' for disabled patients to use the service effectively.

Reasonable adjustments can include changing the way that the service is provided, for example allowing more time for appointments or having a display board to announce the next appointment. They can also include providing communications support, such as a BSL/English interpreter or purchasing helpful equipment, such as a converser. Adjustments don't have to be expensive. Putting a prominent reminder on the patient's electronic and paper notes to tell staff she is deaf or remembering to face your patient and speaking clearly so that he can lip-read you could be a reasonable adjustment. Making reasonable adjustments now can help patients, and save time and money that could be used for patient care.

UK health priorities

A current perception is that ENT conditions are not part of UK health priorities; ENT and audiology have been described as 'a neglected part of the NHS'.² In 2000 the NHS Modernisation Agency launched 'Action On ENT' to look at ways of reducing waiting times for ENT patients.³

Widespread variability in GP referrals and waiting times for elective surgery are hard to explain. Criteria for referral and indications for surgery are clearer since publication of guidelines;^{4,5,6,7} yet there is still a three-fold variation in the rate of GP referrals per 1000 population and many GPs say they would like further training in ENT.⁸

Because head and neck cancer is relatively rare, the average GP would expect to see a new case only every six years.⁹ Early detection of head and neck cancer improves survival, and evidence-based referral guidelines exist but are not widely used.¹⁰

About 800 children are born each year with significant permanent deafness and nearly half of these are not detected early enough by current screening tests¹¹ with significant consequences for behaviour, education and future life chances.

Learning Outcomes

The following learning objectives relate specifically to ENT and facial problems. This RCGP curriculum statement should be used in conjunction with the *core* curriculum statement 1, *Being a General Practitioner*.

Primary care management

- Manage primary contact with patients who have an ENT or facial problem.
- Identify symptoms that are within the range of normal and require no treatment, e.g. cyclical blocking of nose, senile rhinorrhoea, small neck lymph nodes in well children.
- Explain the indications for appropriate referral to an ENT specialist, e.g. recurrent tonsillitis (current guidelines are to refer if more than five attacks in two years or recurrent quinsy), ear drum perforations (pars tensa are safe, whereas pars flaccida are unsafe).
- Identify where services are deficient or frequently have long waiting times for ENT surgery, e.g. audiometry, hearing aids, cochlear implants.
- Describe arrangements for referral to specialist nurse services, e.g. audiometry.

The knowledge base

Symptoms:

- Hearing loss; ear wax, otalgia; discharging ear; dizziness; tinnitus; epistaxis; sore throat, hoarseness; dysphagia; croup; goitre, lymph nodes and other neck swellings; speech delay; foreign bodies; facial weakness.

Common and/or important conditions:

- Otitis media (suppurative/secretory); otitis externa; perforated tympanic membrane; cholesteatoma
- Vertigo; Ménière's disease
- Bell's palsy; tempero-mandibular pain, trigeminal neuralgia
- Pharyngitis; tonsillitis; laryngitis; glandular fever; oral candida, herpes; salivary stones; gastro-oesophageal reflux disease (GORD)
- Infective and allergic rhinitis; sinusitis; nasal polyps
- Nasal fracture, haematoma auris
- Snoring and sleep apnoea
- Suspected head and neck cancer¹²
- Unilateral hearing loss in the absence of external ear pathology or obvious cause.

Investigation:

- Otoscopy

- Tuning fork tests
- Awareness of: pure tone threshold audiogram; speech audiometry, impedance tympanometry, auditory brain-stem responses and otoacoustic emissions
- Investigations may delay referral in suspected head and neck cancer (see Appendix 1).

Treatment:

- Watchful waiting and use of delayed prescriptions
- Nasal cauterisation
- Fractured nose (need manipulation under anaesthetic within two weeks for optimum result).

Emergency care:

- Septal haematoma
- Epistaxis
- Tonsillitis with quinsy
- Otitis externa if extremely blocked or painful
- Foreign body
- Auricular haematoma or perichondritis.

Prevention:

- Screening for hearing impairment in adults and children
- Awareness of iatrogenic causes of ototoxicity.

Person-centred care

- Describe strategies for communicating effectively with patients with hearing impairment and deafness, e.g. remembering to face the patient and speaking clearly so that they can lip-read.
- Demonstrate effective strategies for dealing with parental concerns regarding ENT conditions, e.g. recurrent tonsillitis and glue ear.
- Empower patients to adopt self-treatment and coping strategies where possible, e.g. hay fever, nosebleeds, dizziness, tinnitus.

Specific problem-solving skills

- Utilise knowledge of the relative prevalence of ENT problems to assist diagnosis.
- Describe the alarm symptoms for head and neck cancer, e.g. hoarseness persisting for more than six weeks, ulceration of oral mucosa persisting for more than three weeks.
- Demonstrate appropriate use of time as a diagnostic tool, including clear review procedures and safety netting.
- Understand the likely outcomes of tests, e.g. ear swabs after multiple antibiotic courses always grow *pseudomonas*.

A comprehensive approach

- Describe ENT presentations of systemic diseases, e.g. GORD, cerebrovascular accident (CVA), AIDS.
- Assess the likelihood of occupational exposure as a cause of ENT disease (e.g. industrial deafness).

Community orientation

- Prioritise referrals accurately so people with minor conditions don't compromise the care of those with more serious conditions.
- Describe the national screening programme for hearing loss.
- Understand that certain services have limited availability, e.g. cochlear implants, digital hearing aids.
- Understand the legal implications of the Disability Discrimination Act 1995 including the need for 'reasonable adjustments'.

A holistic approach

- Appreciate the impact of deafness on people's lives. 'Blindness separates people from things. Deafness separates people from people.'¹³
- Demonstrate awareness that certain ENT symptoms can indicate psychological distress, e.g. globus – sensation of not swallowing in a patient who can swallow, the 'dizzy' patient who can walk without difficulty.

Contextual aspects

- Recognise that training in ENT problems has been very limited outside specialist programmes in the past, increasing the risk of inappropriate referrals and under-referral.

Attitudinal aspects

- Ensure that a patient's hearing impairment or deafness does not prejudice the information communicated or doctor's attitude towards the patient.
- Demonstrate empathy and compassion towards patients with incurable disabling ENT conditions, e.g. tinnitus.

Scientific aspects

- Demonstrate a thorough knowledge of the scientific backgrounds of symptoms, diagnosis and treatment, particularly with respect to ENT interventions of dubious efficacy.
- Demonstrate an evidence-based approach to antibiotic prescribing, to prevent the development of resistance, e.g. otitis media.
- Understand and implement the key national guidelines that influence healthcare provision for ENT problems, e.g. Prodigy.¹⁴

Psychomotor skills

- Demonstrate otoscopy.
- Demonstrate ability to perform simple nasal cautery.
- Demonstrate tuning fork tests (Weber and Rinne's tests).

Further Reading

Examples of relevant texts and resources

- BRITISH MEDICAL ASSOCIATION AND ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN. *The British National Formulary* London: BMJ Books, updated annually
- BRITISH MEDICAL ASSOCIATION, ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN, ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH. *The Neonatal and Paediatric Pharmacists Group BNF for Children* London: BMA, 2005
- COLLIER JAB, LONGMORE JM, SCALLY P (eds). *Oxford Handbook of Clinical Specialties* Oxford: Oxford University Press, 2003
- FOXEN EHM AND BULL PD (eds). *Lecture Notes of the Ear, Nose and Throat* London: Blackwell Science, 2002
- CHAGNON F, DEL MAR C, YELLAND M. ENT problems, Section 3. In: Jones R, Britten N, Culpepper L, Gass DA, Grol R, Mant D, et al. (eds). *Oxford Textbook of Primary Medical Care, Vol. 2: clinical management* Oxford: Oxford University Press, 2004; pp. 709–28
- LUDMAN H. *ABC of Otolaryngology (4th edn)* London: BMJ Books, 1997

Web resources

British Deaf Association

www.britishdeafassociation.org.uk

BMJ Topic collections ENT references

<http://bmj.bmjournals.com/cgi/collection/otolaryngology>

British Sign Language

www.britishsignlanguage.com

British Tinnitus Association

www.tinnitus.org.uk

Clinical Evidence

www.clinicalevidence.com/cweb/conditions/ent/ent.jsp

Ménière's Society

www.menieres.org.uk

National Electronic Library for Health and National Electronic Library for Public Health

The aim of the National Electronic Library for Health (NeLH) is to provide clinicians with access to the best current know-how and knowledge to support health care-related decisions. Patients, carers and the public are also welcome to use the site, because the NeLH is open to all. The ultimate aim is for the Library to be a resource for the widest range of people both directly and indirectly.

The main priority for the NeLH is to help the NHS achieve its objectives. However, it is also aimed at those

healthcare professionals who are working in the private sector where common standards should apply. For example, the National Screening Committee is not only an NHS advisory committee, but its mission is also to promote the health of the whole population and its recommendations are relevant to the private sector. Part of the content of the NeLH such as Clinical Evidence and Cochrane Library is licensed from commercial providers. There are two other groups of health and care professionals whose needs will also be met by the NeLH – those working in public health and in social care. The National Electronic Library for Public Health is intended for all public health professionals, many of whom work in local government. It has been developed by the Health Development Agency.

www.nelh.nhs.uk/new_users.asp

www.phel.gov.uk/

PRODIGY Guidance – head and neck cancer – suspected

www.prodigy.nhs.uk/head_neck_cancer_suspected/view_whole_guidance

Other PRODIGY guidelines:

- Allergic rhinitis
- Aphthous ulcer
- Common cold
- Earwax
- Gingivitis and periodontitis
- Glue ear
- Head and neck cancer
- Herpes simplex – oral
- Hiccups
- Ménière’s disease
- Oral candida
- Otitis externa
- Otitis media – acute
- Sinusitis
- Sore throat – acute
- Trigeminal neuralgia.

Royal National Institute for Deaf People

www.rnid.org.uk

Promoting Learning about ENT and Facial Problems

Work-based learning – in primary care

It is important that trainers remember that basic examination skills may need to be taught.^{15,16} In a 1992 study of UK specialty registrars (GP), 50% of respondents commented that they had not experienced teaching or undertaken examination of the ear, nose and throat in adults or children at undergraduate level.¹⁷

A symptom-based approach to teaching is useful using common symptoms (see the knowledge base).

Evidence from Holland shows a significant fall in referral rates over a 14-year-period,¹⁸ perhaps reflecting the trend of decreased surgical intervention for tonsillitis and glue ear. An audit¹⁹ of referrals, by secondary care consultants, indicated a significant number of patients might not need a consultant. Case discussions based on the referral decision for the following common ENT conditions may be profitable:

- Recurrent tonsillitis
- Epistaxis
- Glue ear
- Rhinitis
- Nasal polyps
- Sinusitis
- Snoring
- Sleep apnoea
- Globus
- Otitis externa
- Chronic ear disease
- Hoarseness.

Work-based learning – in secondary care

Specialist outpatient or clinic settings are ideal environments for seeing concentrated groups of patients with ENT and facial problems – particularly for patients who have rare conditions, require specialist treatments or have proven difficult to control in primary care.

Non-work-based learning

Reading, discussion and developing an understanding of the guidelines for ENT problems is an important aspect of learning.

Learning with other healthcare professionals

Joint sessions with colleagues in the primary healthcare team provide multidisciplinary opportunities for learning about the wider aspects of caring for people with ENT problems including deaf people. Involving deaf people in discussions and teaching sessions helps healthcare professionals gain a greater understanding of the problems that deafness brings and will help improve the services that the practice offers to those patients.

Appendix 1

Extract from Referral for Suspected Head and Neck Cancer Guideline

- A patient who presents with symptoms suggestive of head and neck or thyroid cancer should be referred to an appropriate specialist or the neck lump clinic, depending on local arrangements.
- Any patient with persistent symptoms or signs related to the oral cavity in whom a definitive diagnosis of a benign lesion cannot be made should be referred or followed up until the symptoms and signs disappear. If the symptoms and signs have not disappeared after six weeks, an urgent referral should be made.
- Primary healthcare professionals should advise all patients, including those with dentures, to have regular dental checkups.
- An urgent referral should be made for a patient who presents with unexplained red and white patches (including suspected lichen planus) of the oral mucosa that are painful or swollen or bleeding. A non-urgent referral should be made in the absence of these features.
- If oral lichen planus is confirmed, the patient should be monitored for oral cancer as part of routine dental examination.
- In patients with unexplained ulceration of the oral mucosa or mass persisting for more than three weeks, an urgent referral should be made.
- In adult patients with unexplained tooth mobility persisting for more than three weeks, an urgent referral to a dentist should be made.
- In any patient with hoarseness persisting for more than three weeks, particularly smokers aged 50 years and older and heavy drinkers, an urgent referral for a chest X-ray should be made. Patients with positive findings should be referred urgently to a team specialising in the management of lung cancer. Patients with a negative finding should be urgently referred to a team specialising in head and neck cancer.
- In patients with an unexplained lump in the neck that has recently appeared or a lump that has not been diagnosed before that has changed over a period of three to six weeks, an urgent referral should be made.
- In patients with an unexplained persistent swelling in the parotid or submandibular gland, an urgent referral should be made.
- In patients with unexplained persistent sore or painful throat, an urgent referral should be made.
- In patients with unilateral unexplained pain in the head and neck area for more than four weeks, associated with otalgia (earache) but with normal otoscopy, an urgent referral should be made.
- With the exception of persistent hoarseness (see above), investigations for head and neck cancer in primary care are not recommended as they can delay referral.
- In patients presenting with symptoms of tracheal compression, including stridor due to thyroid swelling, immediate referral should be made.

- In patients presenting with a thyroid swelling associated with any of the following, an urgent referral should be made:
 - ◆ a solitary nodule increasing in size
 - ◆ a history of neck irradiation
 - ◆ a family history of an endocrine tumour
 - ◆ unexplained hoarseness or voice changes
 - ◆ cervical lymphadenopathy
 - ◆ very young (pre-pubertal) patients
 - ◆ patients aged 65 years and older.

In patients with a thyroid swelling without stridor or any of the features indicated above, the primary healthcare professional should request thyroid function tests. Patients with hyper- or hypothyroidism and an associated goitre are very unlikely to have thyroid cancer and could be referred, non-urgently, to an endocrinologist. Those with goitre and normal thyroid function tests who do not have any of the features indicated should be referred non-urgently.

- Initiation of other investigations by the primary healthcare professional, such as ultrasonography or isotope scanning, is likely to result in unnecessary delay and is not recommended.

NICE Clinical Guideline No. 19. National Institute for Health and Clinical Excellence. Available from: www.nice.org.uk/guidance/csghn.

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