

NASAL CONDITIONS

Displaced nasal fractures

- Clinical diagnosis – X-rays not indicated
- Refer to ENT clinic by giving appointment card marked “ENT appointment in 5-7 days” to the patient and send them to the ED reception.
- Look for septal haematoma and refer urgently if present.

Epistaxis

- Pack nose lightly with 4% Lignocaine/Adrenaline (bottle in fridge) on ribbon gauze for 5-10 mins.
- Remove pack and examine nose; if bleeding point seen, apply silver nitrate cautery stick 10-15 secs to that area.
- **Children (anterior bleeds more common)**
Children with recurrent minor nose bleeds often respond to a 7 day course of antibiotic cream, e.g., Naseptin.
- **Elderly patients (posterior bleeds more common)**
Those on Warfarin/Aspirin and those with prolonged or recurrent bleeds, require definitive treatment, i.e., cautery. Check BP, FBP and INR when indicated.

Refer to ENT on-call (not clinic) as necessary.

THROAT CONDITIONS

Partial upper airway obstruction (stridor). DON'T TOUCH! Notify both anaesthetist and ENT. (Simple Croup is an exception – give a ‘Pulmicort’ nebuler and refer to paediatrics).

Patients with quinsy have severe pain, trouble with swallowing or opening mouth. Give im Voltarol and contact ENT.

Tonsillitis – see antibiotic protocol, may benefit from steroids +/- Obs ward admission.

FB in throat. Check back of throat for visible FB. X-ray for opaque FB. If clinical suspicion or positive x-ray, speak to ENT.

Bleeding post-tonsillectomy -Resuscitate and refer to ENT for ADMISSION IV antibiotic, e.g., Co-Amoxiclav.
Do not remove clot in tonsil bed!

Ludwigs angina- bilateral cellulitis of the submandibular space. Painful oedema progressing to trismus, dysphagia, drooling and subsequent airway obstruction. Treatment requires Analgesia, Antibiotics (high dose) and Airway Assessment if severe. ADMIT.

Children who swallow coins etc. Do Chest and neck x-ray. If coin (or other inert F.B.) above diaphragm speak to ENT. If coin below diaphragm, reassure and discharge. No review unless abdominal symptoms (rare). Patients who have ingested batteries or other corrosive items should be referred urgently.

- Always check visual acuity
- Apply amethocaine 1% drops for corneal discomfort
- Slit lamp examination for all suspected corneal problems
- Examine using ophthalmoscope any patients with visual disturbance
- X-ray of orbits for all patients with a history of potential penetrating intra-ocular (small F.B. striking eye at high velocity). N.B.: steel striking steel (e.g. hammer and chisel) is particularly hazardous.

EYE PROBLEMS

Patients requiring immediate ophthalmic assessment

- Significant visual loss
- Severe eye pain
- Penetrating ocular trauma and lid lacerations
- Post-operative red or painful eye

These patients should be referred to the ophthalmology SHO on-call or eye casualty in RVH **Phone 90634706**

Patients requiring early (within 24 hrs) referral to the Eyes Clinic:

- Iritis (pain, photophobia, circumcorneal red eye, cloudy cornea)
- Retinal detachment (flashes, curtains, post-traumatic visual upset)
- Hyphaema
- Dendritic ulcers (pain, photophobia, staining lesion on cornea)
- Alkali chemical burns

Contact RVH ophthalmology SHO for appointment in Eye Casualty