EAR CONDITIONS

- **Foreign body in child's ear -**
  It's tempting to try but only remove if visible and child co-operative. Check TM afterwards.

- **Otitis externa**
  Often requires strong analgesia
  Insert pope ear wick for 24-48hrs
  Antibiotic/steroid drops e.g. Betnesol-N for 7 days only (risk of ototoxicity if use prolonged in presence of TM perforation).
  Refer severe cases to ENT for aural toilet.
  Review by GP.

- **Otitis media**
  Strong analgesia.
  Oral antibiotics (see protocol).
  Always review by GP to ensure resolution**.**

- **Traumatic TM perforation**
  Keep ear dry.
  No antibiotics required.
  GP to arrange ENT review within a few weeks.

BELLS PALSY

i.e., idiopathic LMN VIIth (facial) nerve palsy involving entire half of face

Examination:

- Exclude other cranial nerve involvement.
- Examine throat and ear for herpetic vesicles or middle ear infection.
- Examine for serious underlying pathology e.g. Lyme disease, parotid tumour

Treatment:

- Prednisolone 40mg daily and 5 day course of oral Acyclovir
- Eye protection with artificial tears or Lacrilube gel and eye patch at night (if unable to close eye).
- Discuss with ENT doctor for review in 3-5 days and
- 80-90% full recovery expected for uncomplicated Bell's.
- Refer to ENT clinic for review in 5-6 weeks (this can be arranged by ED reception staff)

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' nebule 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 submadibular 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

Conditions suitable for ED management:

- Corneal foreign body (remove with cotton bud or orange needle, don't forget to evert upper lid)
- Conjunctivitis (chloromycetin ointment four times daily for five days)
- Corneal abrasion including abrasions caused by foreign body removal (cyclopentolate, chloramphenicol and voltarol drops applied stat, then eye pad)
- Non-alkali Chemical burn (check pH, irrigate immediately with several litres of normal saline until pH returns to neutral, remembering to evert upper lid. Refer to ophthalmology SHO if unable to normalise pH
- Welder's flash (amethocaine 1%, cyclopentolate and voltarol drops, chloromycetin, double eye pad and bandage)

Conditions that should be reviewed at the Emergency Department:

- Corneal abrasion causing reduced visual acuity (5 days)
- Rust ring if over the pupil (5 days)
- Non-alkali chemical burn (next day)
- Welder's flash if not settling