Surrey and Sussex Healthcare
NHS Trust

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ENT
Departmental Guide
September 2019

Introduction to the Department

The department of Otorhinolaryngology Head and Neck Surgery (ENT) at East Surrey Hospital NHS Trust provides elective and emergency services for the county of East Surrey and West Sussex and elective day surgery at Crawley Hospital. We have additional clinics at Horsham and Caterham. We run specialist clinics in Head & Neck surgery, rhinology and Dizzy clinics. Weekly teaching sessions are run every Friday morning in the postgraduate education centre.

There are 5 consultants, 1 associate specialist, 4 Specialty doctors (middle grade) and 1 core trainee, 2 GP trainees and 3 trust grade doctors. Emergency work is based at East Surrey Hospital in A&E and emergency clinics are run at the Surgical Assessment Unit (SAU). ENT patients are admitted to Brook ward (adults) and Outwood ward (children).

We are a friendly department and hope you will find your time with us educational and enjoyable. As with all jobs the more you put in the more you get out- please do make an effort to attend clinics, theatres, and departmental meetings.

Before you begin

On your first day you should come to Brook ward at 8.30am. You will receive an induction with our department in addition to the trust induction.

If you are new to the specialty of ENT we suggest some revision prior to starting the job. We run a regional “Introduction to ENT course” which we strongly recommend you attend. For reading we suggest:

The Basics:
Essential ENT (2nd Edition) R. Corbridge. Hodder Arnold 2011

Quick Reference:
Otolaryngology and Head and Neck Surgery (Oxford Specialist Handbook). G. Warner, A Burgess, S. Patel, P. Martinez-Devesa, R. Corbridge. OUP 2009

Definitive Reference:
Scott-Brown’s Otolrhinolaryngology, Head and neck surgery. M Gleeson. 2008

There are also videos on ENT clinical examination and practical skills at:

http://www.tmax.co.uk/clients/clinicalaids/

Staff

Consultants

Name	Hospitals	Special Interests	Secretary
Humera Babar-Craig	East Surrey Hospital Crawley Hospital	Rhinology	Nicky Ext 6847
Natasha Choudhury	East Surrey Hospital Horsham Hospital	Thyroid Surgery	Nicky Ext 6847
Karan Kapoor	East Surrey Hospital Horsham Hospital	Head & Neck Surgery	Kay Ext 2968
Sameer Khemani	East Surrey Hospital Crawley Hospital	Otology	Justine Ext 3698
Waleed Ziyada	East Surrey Hospital Horsham Hospital	Laryngology	Kim Ext 3337

Other Important People/Numbers

Tobias Tipper – ENT Service Manager	Ext 6208
Sarah Stephens – Waiting list Officer	Ext 2896
Patricia Brook – Head of Pre-assessment	Blp 806
Faye – Audiology, Crawley Hospital	Ext 3137
X-Ray – Jo Macauley	Blp 600
Radiology – Dr Gwythers	Ext 6005
RAST Allergy Test results	01273 696 955 / Ext 4593
Shirley – Anaesthetics secretary	Ext 6046
Val Delamier – SALT	Ext 6085
IT Dept	Ext 1717

Structure of the Department

Wards & Theatres

Our adult ward is Brook ward and Paediatric ward is Outwood. We do a ward round every day at 8.30am starting on Brook ward. All doctors who are not scheduled to be in theatre or at a peripheral clinic are expected to attend the daily ward round. Operating lists start at 8.30am, usually in theatre 5 at East Surrey hospital.

Day to day work

We use a computer based system for checking blood results, path results, microbiology and Cerna for visualizing radiology and reports.

- Every day please ensure that the results of tests have been checked and documented in the notes, including blood tests, radiology results and microbiology results.
- Every patient needs a venous thrombo-embolism (VTE) assessment on admission, and again after 72 hours. This is audited across the trust.
- If an antibiotic is prescribed please ensure that you document the indication for use and the duration in the notes and on drug charts. Again this is audited across the trust.
- Please complete dementia screening assessment on all patients above 75 years old.
- All ENT paediatric patients admitted under ENT must be discussed with the paediatric team to ensure joint/best management. This is to ensure that the paediatric team are aware of all admitted children.
- Complete discharge summaries for all patients. This serves as a record of the hospital encounter and is sent to the GP but is also the means by with department activity and consequently source of income is determined.
- There is a database on which we keep a record of all morbidity and mortality e.g. post operative complications. These must be presented weekly at the departmental meeting.
- Please be careful with printed patient lists or other confidential information. Lists are now recorded electronically. There are instances of patient lists being left in public places, which the Trust regards as very serious.
- Every Friday morning there is a compulsory teaching session at 9.00am which is lead by the consultant on call for that weekend. This is followed by a presentation by the day SHO of the weekly departmental activity.

On-call/ Duties

The daytime on call (8am---5pm) is covered by an allocated registrar each day, who also leads the ward round that day. Evening on call for registrars (5pm---8am) is non---resident (within half an hour drive). Weekends are 48 hour shifts on Saturday and Sunday.

Handover for oncalls: Brook Ward

Duties:

Day on call - Ward round with Registrar, ward jobs, SAU clinic, taking emergency referrals.

SAU clinic (ENT rapid access clinic) runs Monday - Friday from 11.30 - 2pm (5 patients, 1/2 hour appointments). Please make sure to fill in what procedures you have done on the white form so the department can get paid for it.

Night on call - to do the discharge summaries for patients going home the next day, taking emergency referrals.

Short Day - This is your educational day - choice between theatres or clinics. You are also the booster for the on call SHO if it becomes too busy.

Crawley Day - Theatres in the morning followed by clinics in the afternoon.
Theatre ½ Day – Theatres until 12:00

Other notes:

- Hearing Tests for inpatients / SAU patients can be booked in daily between 13:00–14:00.
- When equipment supplies are running low in our SAU clinic room, please let the sister know so she can order some in.
- There is no SAU clinic over the weekends – please do not book any patient in unless it is urgent.
- Patients who are seen on the Child Assessment Unit (CAU) need discharge summaries done and printed out.
- IT IS THE RESPONSIBILITY OF THE DAY AND NIGHT SHO'S TO FILL IN VTES AND DEMENTIA SCREENS FOR ALL PATIENTS THAT ARE ADMITTED, AND TO CHECK THAT PATIENTS POST OP WHO ARE STAYING IN ALSO HAVE VTES DONE. This is constantly monitored by the lead clinician and the ENT manager. Any VTEs not done will be flagged up with the person that was on call that day.

Annual Leave and Study Leave

Annual Leave:
9 Days per 4 months = 27 days per annum
To be signed by the rota co-ordinator and counter signed by Mr Khemani.

Study Leave:
Information regarding budgets and access to forms can be found here:
https://sasheducationcampus.net/medical-education/study-leave/

Forms must be signed by the rota co-ordinator and your Educational Supervisor, before being submitted to the Postgraduate Centre 8-weeks before the requested leave required.

Surgical Assessment Unit (SAU)/ Emergency Equipment

- There is a microscope and other emergency equipment in the treatment room in SAU.
- Nasendoscopes for emergency use and SAU clinic use are also kept in the treatment room on SAU. Please be careful not to bend the fibre-optic cables when using or packing away scopes, they are easily damaged and costly to repair. When you use an endoscope place the decontamination sticker into the patient's notes and take a sticker with the patient's details in the decontamination log in SAU. Please can you decontaminate it (using Tristel wipes). If required, spare adult scopes can be obtained from ENT outpatients or from main theatre.
- Tracheostomy sets are kept in ITU and theatres.

Emergency operating

- During normal working hours (Weekdays, 8am to 5pm), emergency cases need to be scheduled into elective ENT operating lists where possible. There is a CPOD emergency operating theatre for urgent cases or for children if there are no Paediatric lists for ENT that day. Speak to the operating surgeon, the anaesthetist and the theatre team. Elective cases may need to be cancelled for emergency operating.

- Out of hours there is an emergency CPOD operating theatre. Book the case through the anaesthetic coordinator (bleep), and by filling in an emergency booking form (the anaesthetic coordinator can advise). The anaesthetic coordinator can also give you details of the emergency anaesthetist, who of course also needs to be informed of the case.

Guidelines for the management of specific emergencies

Bronchial foreign body
If there is suspicion of an inhaled foreign body in a child they should be brought in for assessment and chest X-ray. If clinical suspicion remains (regardless of radiology findings) the patient will need a bronchoscopy (urgently if the child is compromised). If not compromised children under 2-years old should be transferred to specialist unit eg Great Ormond St, Evylena, St Georges.

Epistaxis
A step-wise approach to management.
1. Pressing on the bleeding point (pinch and hold the lower half of the nose for at least 5 minutes).
2. Cautery, e.g. silver nitrate.
3. Anterior nasal packing (e.g. Rapid Rhino pack) on side of bleed.
4. Bilateral anterior nasal packing 5. Posterior packing (e.g. urethral catheter) and bilateral

anterior packing with BIPP. 6. Surgery (e.g. sphenopalatine artery ligation). Any patient who is packed needs admission, iv cannulation, bloods (FBC, clotting, group & save). Stop aspirin or warfarin, unless high risk (e.g. prosthetic heart valve), in which case discuss with haematology. After 48 hours of nasal packing consider Augmentin cover.

Facial lacerations
These are repaired by either A&E, Max Fax or ENT. ENT may get involved if the laceration involves the nose or the pinna.

Facial palsy
Bell's palsy is only diagnosed when there is no underlying cause. If there is a history of recent head trauma or evidence of middle ear disease, ask the ENT SpR for advice. If there is no cause, recommend oral steroids (40mg prednisolone od for a week) and eye care if necessary, and recommend GP follow up. 80% of Bell's palsy will fully recover.

Fish bones
With an acute history, these should be seen ASAP. If the history stretches over several days, it is reasonable to see them urgently in e-clinic. The majority impact in the tonsil or tongue base and can be removed under direct visualization (tongue base bones often necessitate an intubating laryngoscope to aid extraction).

Foreign body nose / ear
See same day if possible, but if referred from a peripheral hospital or GP, see the following morning (inert ear foreign bodies can wait longer). Exception is button batteries which must be removed ASAP. If unsure whether a foreign body may be a battery, obtain an x-ray.

Food bolus obstruction
If total dysphagia, admit and give iv fluids, buscopan and/or diazepam (not in children). Perform a lateral soft tissue x---ray of neck if a bony foreign body, and if possible perform nasendoscopy. If the suspected site of impaction is not the upper oesophagus (i.e. cricopharyngeus), then refer to gastroenterology. If the food bolus includes bone, then urgent removal is needed.

Mastoiditis
This really refers to a subperiosteal mastoid abscess. There is a tender post-auricular fluctuant erythematous swelling, the pinna is pushed forward and the patient is often pyrexial. Admit for iv antibiotics (co-amoxiclav). May need surgical drainage if septic or fails to settle.

Nasal injury
Suspected closed nasal fractures can be referred to SAU clinic to be seen 7-10 days after injury (after a week the soft tissue oedema is improved and the nasal skeleton can be assessed). X-ray is not required. At the time of injury a septal haematoma should be excluded, if present this will require needle aspiration or drainage, and nasal packing. If Manipulation is required book urgent MUA of nose as Day case at Crawley if adult and ESH if child, with Sarah (waiting list co-ordinator).

Neck injury (penetrating)
Superficial injuries are managed conservatively. Any wound that has penetrated deep to platysma should be discussed with the on call registrar as there is a risk of occult injury to the vasculature. Do not explore deep wounds in A&E.

Otitis externa
Can usually be referred to SAU clinic. See urgently and consider admission if severe pain, fever, or spreading pinna/facial cellulitis. Treatment is microsuction of debris from external ear, antibiotic ear drops (e.g. ciprofloxacin 0.3%, two drops tds), and oral
antibiotics if spreading onto pinna (co-amoxiclav). Beware the diabetic (or otherwise immunocompromised) patient with severe pain from otitis externa, this could be a sign that infection has spread into bone (admit and perform a CT scan temporal bones). Patients can be re-booked for microsuction in SAU clinic. After 3 reviews in SAU clinic consider referral to main clinic.

Otitis media
Usually self limiting and does not usually need admission. Recommend analgesia. Consider antibiotics (co-amoxiclav) if bilateral disease, in children under the age of two, or for symptoms that have not improved for more than 48hrs.

Periorbital cellulitis
Usually occurs as a complication of ethmoid sinusitis. Discuss urgently with ENT SpR and also ask for ophthalmology review. Requires antibiotics (co-amoxiclav), and nasal decongestant drops (ephedrine). If there is a suspicion of orbital abscess, will need an urgent CT orbits/sinus with a view to surgical drainage.

Pinna Haematoma
Needs to be seen within 24 hours of injury. Drain with needle aspiration or incision, and packing.

Post tonsillectomy bleed
All need admission for observation as even a small bleed can herald a more serious bleed. Prescribe antibiotics (co-amoxiclav) for presumed infection. Ensure iv access and baseline bloods including FBC and at least a group and save. Persistent or repeated bleeding needs to go to theatre.

Sinusitis
Unless complicated by intraorbital or intracranial spread of infection, this can be treated by GP or A&E. Give nasal decongestants (ephedrine) and consider giving antibiotics (e.g. co-amoxiclav).

Speaking valve loss / leakage
If a speaking valve comes out the puncture site must be cannulated to keep it patent. You can insert a nasogastric tube, or preferably replace the valve. Spare valves are kept with the SALT team. Discuss with SpR and consider transfer to Guildford hospital.

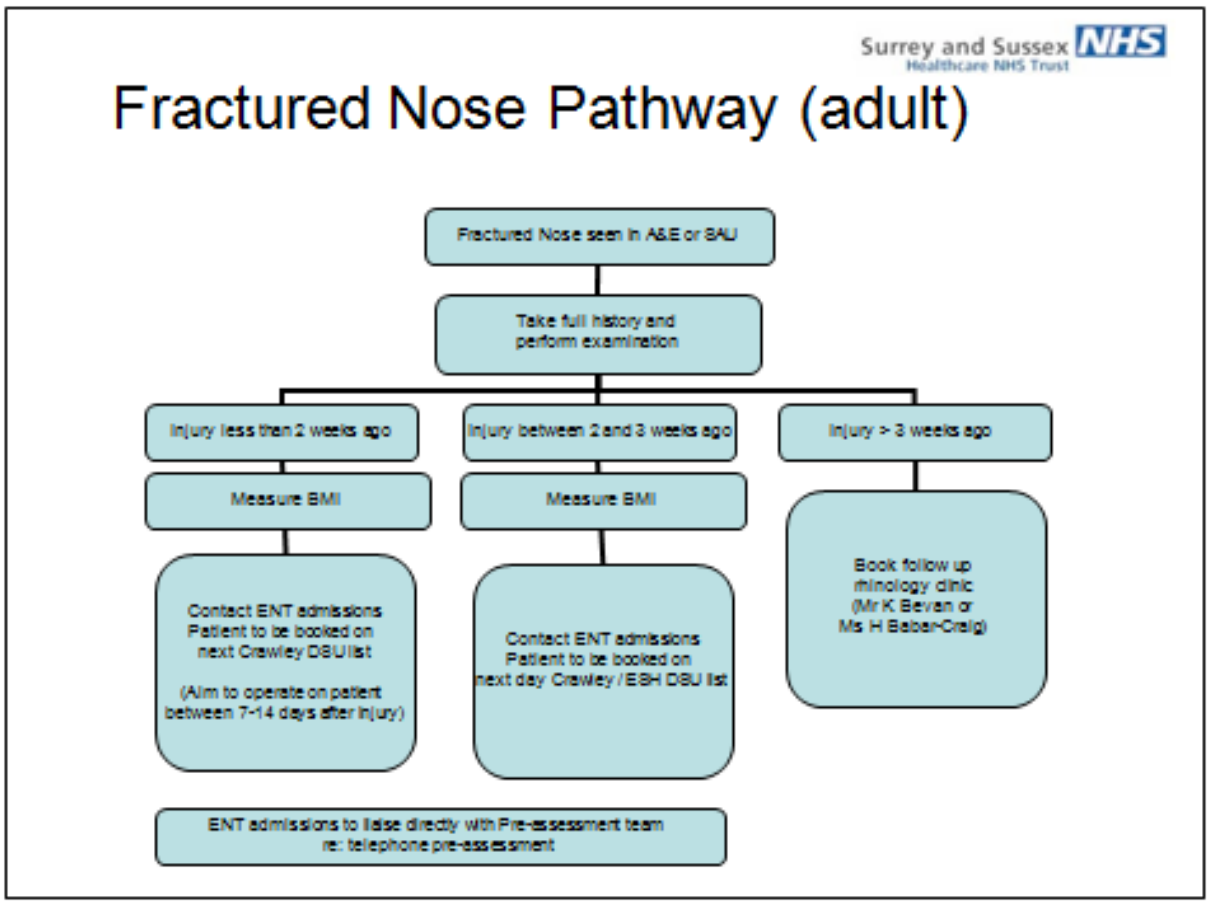
Stridor
Needs assessment by SpR. Can be due to a number of cause, e.g. supraglottitis or laryngeal cancer. Give oxygen, 8mg dexamethasone iv tds, adrenaline nebuliser
(1ml of 1:1000 in 10mls normal saline), co---amoxiclav (cefuroxime if supraglottitis is suspected). Stridor in children needs urgent assessment by ENT SpR and paeds SpR. Paediatric or adult anaesthetists may also need to be involved.

Sudden hearing loss (idiopathic)
Try to ascertain type of hearing loss using tuning forks and otoscopy to exclude outer or middle ear disease. If sudden sensorineural hearing loss, the cause is unclear but
recommend steroids (40mg prednisolone od for a week). Two---thirds will recover. They can be followed up in the routine ENT clinic.

Tonsillitis / Quinsy
Admit if unable to eat and drink, or if septic and not responding to oral antibiotics. Prescribe iv penicillin (erythromycin if allergic) and metronidazole, iv fluids,
analgesia. Document whether there is a neutrophilia (suggesting bacterial tonsillitis) or lymphocytosis (suggesting glandular fever --- GF), and consider sending a GF screen (Monospot). Quinsy requires drainage or needle aspiration, except in a child, where a trial of antibiotics is warranted. One dose of IV Dexamethasone 4mg often reduces swelling and pain.

Tympanic membrane perforation (traumatic)
Almost all will heal. Advise the patient to keep the ear dry. Consider prescribing topical antibiotic drops (e.g. ciprofloxacin 0.3%, two drops bd). GP follow up.

Antibiotic Prescribing
Care Pathways/Protocols



Periorbital Cellulitis Pathway

Management of thyroidectomy patients post-operatively

INPATIENT MANAGEMENT:

Post – op Flexible Nasoendoscopy

All thyroidectomy patients need a vocal cord check within 24hrs of surgery.

Drains

Drains can be removed when there is less than 30mls drainage in 24 hours.

Calcium check

Only total or completion thyroidectomy patients need a calcium check (thyroid lobectomy or hemithyroidectomy patients do not need calcium check).

1st serum calcium at 6 - 8 hours on day 1 post-op, followed by following morning then 24hrly thereafter. Calcium replacement is ONLY indicated if the corrected calcium falls below 2mmol/l or if patients develop symptoms.

Serum magnesium and phosphate levels should also be monitored and corrected.

Symptoms of hypocalcaemia include: peri-oral paraesthesia, paraesthesia and numbness of extremities, muscle weakness, malaise, myalgia, cramps; confusion/altered state, seizures and tetanic contractions including laryngospasm.

National Patient Safety Alert (NPSA) alert 2011 on the safety of prescribing alfacalcidol: the terms "nanograms" and micrograms should not be abbreviated and decimal points should NOT be used.

MANAGEMENT ON DISCHARGE:

Thyroid hormone replacement
Thyroid hormone replacement IS NOT REQUIRED routinely following thyroid lobectomy / Hemithyroidectomy. Following a total or completion thyroidectomy, patients should be started on levothyroxine 125mcg once a day.
Calcium supplementation (only for total thyroidectomy)
There is a policy on Brook ward that says for cCa 1.7-2 use sandocal 1000 tablet 1TDS. Check cCa on day 2 and if 1.7-1.9 addalfacalcidol 0.5mcg OD or if <1.7 add 1mcg alfacalcidol OD

GP to check calcium levels 7 days following discharge.
Patient commenced on calcium supplements should continue with this following their discharge
Follow-up:

All patients to be seen in next Joint thyroid clinic (occurs on monthly basis on Friday).
All total and completion thyroidectomy patients should be discharged with a blood form to have their calcium levels checked 48 hours prior to clinic
Sutures:
All absorbable sutures, and therefore do no need to be removed.

Periorbital Cellulitis Pathway

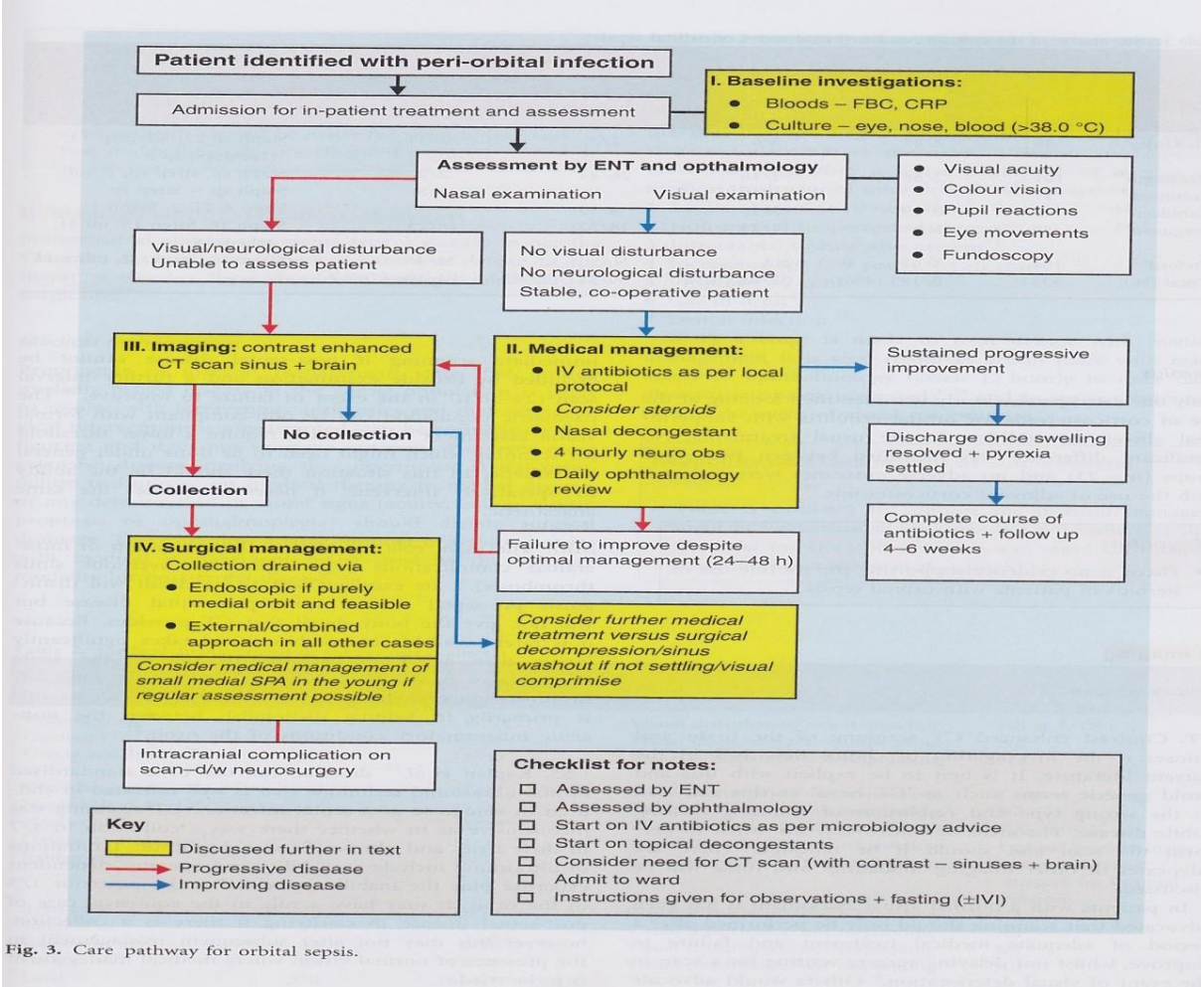


Fig. 3. Care pathway for orbital sepsis.