Health Plan of Nevada
A UnitedHealthcare Company

## 11.5 EAR NOSE AND THROAT REFERRAL GUIDELINES
**Contracted Group: Ear Nose and Throat Consultants (ENTC)**

**For Appointments:**

**Telephone Number: (702) 792-6700** **Fax: (702) 792-7198**

**Locations:**

3195 St. Rose Parkway, Suite 210
Henderson, NV 89052

7040 Smoke Ranch Road
Las Vegas, NV 89128

8840 W. Sunset Road, Suite A
Las Vegas, NV 89148

## *Important Note:*

*****Please have Patients bring their films to their appointments as indicated below.**

*****In order for patients to be seen at the time of their appointment we will need requested documentation.**

| THROAT<br>PLEASE send documentation for recurrent episodes | | |
|---|---|---|
| **DIAGNOSIS** | **EVALUATION** | **CONDITIONS FOR REFERRAL** |
| **PHARYNGEAL AND TONSILLOADENOID PROBLEMS**<br>• Streptococcal Pharyngitis/ Acute Tonsillitis | Throat pain & odynophagia with any of the following<br>Findings:<br>1. Fever<br>2. Tonsillar exudate<br>3. Lymphadenopathy<br>4. Positive Strep Test | **Documented** episodes:<br>• 7 or more in previous 12 Months, treated with antibiotics.<br>• 5 per year in 2 preceding years, treated with antibiotics<br>• Persistent streptococcal carrier state with or without acute tonsillitis.<br>• Peritonsillar Abcess (Acute) |
| • Chronic Tonsillitis | Frequent or chronic throat pain and odynophagia; may have any of the following findings:<br>• intermittent exudates<br>• adenopathy<br>• improves with antibiotic | ENT referral is indicated if problem recurs following adequate response to therapy<br>As for recurrent acute tonsilitis.<br>3 infections, treated with antibiotics, for 3 or more consecutive years. |
| • Mononucleosis | Throat pain & odynophagia with:<br>• fatigue<br>• posterior cervical adenopathy<br>• CBC, mono test (Required for referral) | Airway obstruction<br>*Needs ER referral.*<br>***CBC***<br>***MONO TEST*** |

| DIAGNOSIS | EVALUATION | CONDITIONS FOR REFERRAL |
|---|---|---|
| • Adenoiditis | 1. Purulent rhinorrhea<br>2. Nasal obstruction<br>3. Cough<br>4. May be associated with otitis media | 1. As for tonsillitis<br>2. Persisting symptoms and findings after two courses of antibiotics |
| **UPPER AIRWAY OBSTRUCTION*:***<br><br>• Tonsillar and/or adenoid hyperplasia | 1. Mouth breathing<br>2. Nasal obstruction<br>3. Dysphonia<br>4. Severe Snoring with or without apnea<br>5. Daytime fatigue<br>6. Dysphagia<br>7. Weight and/or height below normal for age<br>8. Dental arch maldevelopment: narrow arched palate, cross bite deformity<br>9. Adenoid facies<br>10. Cor pulmonale<br>11. ***Polysomnogram*** | ENT referral indicated with significant symptoms of upper airway obstruction,<br>***Polysomnogram Results***<br><br>***If Acute ER Referral Should be Made*** |
| • Tonsillar Hemorrhage | Spontaneous bleeding from a tonsil | ENT/ER referral is indicated |
| • Neoplasm | Progressive unilateral tonsil enlargement | ENT referral is indicated |
| • Hoarseness, Associated with respiratory obstruction | Stridor | IMMEDIATE ***ER*** REFERRAL IS INDICATED IN ALL CASES |
| • Hoarseness without associated symptoms or obvious etiology | 1. History of tobacco and/or alcohol use<br>2. Evaluation, when indicated, for:<br>• Hypothyroidism<br>• Diabetes mellitus<br>• Gastro-esophageal reflux<br>• Rheumatoid disease<br>• Lung neoplasm<br>• Esophageal or pharyngeal neoplasm | ENT referral is indicated if hoarseness persists more than two weeks despite medical therapy |
| **DYSPHAGIA** | GI Consultation<br><br>***Barium Swallow results needed***<br><br>(General Dysphagia referral go to GI) | ENT referral indicated for:<br><br>1. Foreign body suspected in the pharynx/larynx (esophageal foreign bodies NOT for ENT)<br>2. Dysphagia in children<br>3. Dysphagia assoc. with hoarseness<br>4. Modified Barium Swallow Results for Adults |

| DIAGNOSIS | EVALUATION | CONDITIONS FOR REFERRAL |
|---|---|---|
| **NECK MASS**<br><br>• Inflammatory | 1. Head and Neck examination- **Dental source**?<br>2. ***CT NECK with contrast and Fine Needle Aspirate with/without Ultrasound guidance*** (needed for referral)<br>3. ***CBC***<br>4. Cultures if indicated<br>5. ***TB test***<br>6. Inquire about possible cat scratch<br>7. HIV testing if indicated<br>8. Toxoplasmosis titre if indicated | ENT referral is indicated if:<br>Mass persists for 2 weeks without improvement after medical management (PCP treatments)<br><br>URGENT referral if painless progressive enlargement<br><br>URGENT referral if suspicion of metastatic carcinoma ***(PT MUST BRING CT FILMS and FNA RESULTS TO BE SEEN***) |
| **NECK MASS**<br>• Non-inflammatory | Complete head and neck examination indicated<br>If lower neck, thyroid evaluation may include:<br>• Thyroid function studies<br>• Thyroid ultrasound<br>• Thyroid uptake and scan<br>• Needle aspiration biopsy<br>Open biopsy of neck mass is contra indicated in all cases | ENT referral is indicated other than for THYROID or PARATHYROID disorders<br><br>***CT NECK, FNA NEEDED TO BE SEEN***<br><br>***PT MUST BRING CT FILMS and FNA Results TO BE SEEN***<br><br>***CT Neck with contrast***<br>***Fine Needle Aspirate with or without Ultrasound guidance*** |
| **SALIVARY GLAND DISORDERS**<br><br>• Parotiditis | 1. Assess hydration of patient<br>2. Palpate for stones in floor of mouth<br>3. Observe for purulent discharge from salivary ducts when palpating involved gland<br>4. Evaluate mass for swelling, tenderness, inflammation<br>5. ***CT of Neck with contrast***. | ENT referral indicated :<br>1. Poor antibiotic response within one week of diagnosis<br>2. Calculi or mass suspected on exam and **CT (*PT MUST BRING CT FILMS TO BE SEEN*)**<br><br>3. Abscess formation-immediate referral |
| **SALIVARY GLAND MASS**<br><br>• Dysgeusia with suspected mass<br><br>(Dysgeusia without suspected mass-refer to neurology) | 1. Complete head and neck examination<br>2. Evaluate facial nerve function<br>3. CT or MRI neck WITH contrast required<br>Open biopsy of salivary mass is contra-indicated in all cases | ENT referral is indicated in all cases of salivary gland neck masses<br><br>***CT NECK, FNA NEEDED TO BE SEEN***<br><br>***PT MUST BRING CT FILMS AND FNA RESULTS TO BE SEEN.***<br><br>CT Neck with Contrast ***NEEDED FOR REFERRAL***<br>Fine Needle Aspirate with or without Ultrasound Guidance ***NEEDED FOR REFERRAL*** |

| DIAGNOSIS | EVALUATION | CONDITIONS FOR REFERRAL |
|---|---|---|
| **SLEEP APNEA & SNORING** | Symptoms of obstructive sleep apnea may include:<br>Sleep Medicine Eval<br>Evaluation may include:<br>• Polysomnography | ENT referral indicated **after 1 month CPAP home trial**<br><br>1. Evaluation of upper airway and nasal obstruction<br>2. Abnormal Polysonogram and considering surgical options ***AFTER 1 MONTH*** CPAP trial and Sleep Medicine Eval ***NEEDED FOR REFERRAL. Please include results in referral.***<br>3. Elective management of snoring in absence of sleep apnea<br>***(Pt. <u>needs</u> to bring copy of studies)*** |

## NASAL AND SINUS PROBLEMS, ADULT

Caveats:
ENTC does not have access to SMA radiology or labs
Definitive sinus diagnosis requires CT scan: **CT must be done at least 2 weeks after acute episode**
(CT sinus without contrast) Please have patient bring films (not just reports) or **patient cannot be seen**

| DIAGNOSIS | EVALUATION | CONDITIONS FOR REFERRAL |
|---|---|---|
| **EPISTAXIS (NOSEBLEED); PERSISTING OR RECURRENT** | Determine whether:<br>Bleeding is unilateral or bilateral<br>Bleeding is anterior or posterior<br>Any bleeding diathesis or hypertension<br>Coagulation studies | 1. Bleeding is posterior<br>2. Bleeding persists (Despite PCP Treatment) ***AND STOPPING ANTI-COAGULENTS***<br>3. Bleeding recurs<br>4. Discontinue anticoagulants prior to referral for packing removal |
| • Chronic sinusitis/polyps<br>• Anosmia/Dysosmia with sinus symptoms.<br><br>(Anosmia/Dysosmia WITHOUT sinus symptoms-refer to Neurology) | Symptoms: persisting or recurrent<br>Nasal congestion (unilateral or bilateral)<br>Post-nasal discharge<br>Epistaxis<br>Recurrent acute sinusitis<br>Anterior facial pain/ headache (SINUS HEADACHE)<br>CT Sinus WITHOUT contrast or MRI Brain REQUIRED for referral<br>• ***CT scan of Sinus*** shows abnormal findings, MORE THAN MILD.<br>• ***<u>CT Scan normal, must f/u with PCP</u>*** | **<u>*CT to BE DONE after treatment attempts*</u>**<br>1.Recurrent three episodes per year, failing 3 antibiotic trials, one at least 14 days<br>2. Failure of medical management including use of oral and/or topical steroids, saline irrigations, decongestants, treatment of allergic rhinitis and antibiotics as above.<br>3. CT Scan Sinuses without contrast after failing medical management as above. (***PATIENT MUST BRING FILMS***).<br>***CT results must indicate more than minimal or mild disease or MORE THAN small cyst polyp FOR ACCEPTABLE REFERRAL.*** |
| • Deviated Septum | Symptoms:<br>Nasal congestion (unilateral or bilateral)<br>Post-nasal discharge<br>Epistaxis<br>Recurrent sinusitis<br>Anterior facial pain headache.<br>Physical Examination | ENT referral if medical allergy management failure and exam shows deviated septum. |

| | | |
|---|---|---|
| **DIAGNOSIS** | **EVALUATION** | **CONDITIONS FOR REFERRAL** |
| • Allergic Rhinitis/Post Nasal Drip | **Symptoms:**<br>**Seasonal or perennial; congestion**<br>**Watery discharge**<br>**Sneezing fits**<br>**Watery eyes**<br>**Itchy eyes/throat.**<br>Physical Examination: boggy swollen bluish turbinates<br>Allergic "shiners"<br>"Allergic salute." | **Refer to ALLERGIST**<br>***If suspicious of Sinusitis, see above.*** |
| • Acute nasal fracture | 1. Immediate changes: edema, Ecchymosis, epistaxis.<br>2. Evaluate for associated nasal congestion, septal fracture of septal hematoma.<br>3. Nasal bone X-rays usually positive. | 1. Immediate referral if possible septal hematoma (significant airway obstruction).<br>2. ENT referral in approximately 7-10 days if external nasal deformity, septal deformity, or breathing problem.<br>***(ENT DOES NOT CONTRACT FOR FACIAL BONE FRACTURES EXCEPT FOR NASAL BONES)*** |

## EAR PROBLEMS, CHILDHOOD

Caveats:
The so called "light reflex" is not a valid indicator of ear health
Absence of the so-called "light-reflex" is not a valid indicator of ear disease
In a crying child, one may see uniform injection of tympanic membrane without infection
Otoscopic examination is NOT capable of evaluating middle ear negative pressure
Otoscopic examination is often NOT adequate for identifying non-infected middle ear effusion
Otoscopic examination is often NOT adequate for identifying tympanic membrane retraction
Pneumo-Otoscopic examination improves reliability for identifying middle ear effusion/pressure/retraction
Tympanometry provides high reliability for identifying middle ear effusion/pressure (though it is not infallible)

| DIAGNOSIS | EVALUATION | CONDITIONS FOR REFERRAL |
|---|---|---|
| **ACUTE OTITIS MEDIA**<br>"Ear infection" | **1) Symptoms: ear pain, decreased hearing, ear drainage, fever**<br>2) Physical Examination: Inflamed tympanic membrane TM, desquamated epithelium on TM, bulging TM, middle ear effusion<br>3) Audio (not required if A & B are present) tympanogram may show positive or negative pressure<br>4) Caveat: Tender, swollen ear canal usually indicated external otitis rather than otitis media | Chronic otitis media criteria<br>1) Secondary antibiotic treatment fails<br>2) Complications are noted mastoiditis, facial weakness, dizziness, meningitis |

| DIAGNOSIS | EVALUATION | CONDITIONS FOR REFERRAL |
|---|---|---|
| **CHRONIC OTITIS MEDIA**<br>i.e., persistent effusion or negative middle ear pressure, with or without recurrent acute otitis media | MAY HAVE NO SYMPTOMS: pneumotoscopy and/or tympanogram are crucial<br>1) Symptoms: ear pain, decreased hearing, ear drainage<br>2) Physical Examination: (may include) TM discolored thinned, or retracted; bubbles behind TM, Pneumo-otoscopy reveals sluggish or retracted TM.<br>3) Audio: tympanogram may show effusion (type B) or negative pressure (type C) | 1) Recurring otalgia or hearing loss (3 episodes in 6 months)<br>2) Effusion, TM retraction, perforation, or negative pressure persist > 3 months<br>3) Ear discharge (persisting or recurrent)<br>4) Abnormal tympanogram and/or audiogram after 3 months |
| **ACUTE EXTERNAL OTITIS**<br>"Swimmers Ear" | 1) Symptoms: ear pain, significant EAR TENDERNESS, swollen external canal, hearing may or may not be diminished<br>2) Physical Examination: Ear canal always tender, usually swollen, may be inflamed. Often unable to visualize TM because of debris or canal edema<br>3) Caveat: Occasional cases have a large fungal pad indicating fungal external otitis-often spores visible | 1) Canal is swollen shut and wick cannot be inserted<br>2) Cerumen impaction compounding external otitis<br>3) Unresponsive to initial course of wick and anti-bacterial drops<br>**Avoid Cortisporin Otic due to high allergy rate.**<br>***FAILURE OF TOPICAL TREATMENT*** |
| **HEARING LOSS**<br><br>**BILATERAL,**<br>SYMMETRICAL, ADULTS (FOR CHILDREN, SEE ABOVE) | Symptoms: diminished hearing<br>1) Cerumen blockage<br>2) Middle ear effusion<br>3) Normal findings | 1) Cerumen, or hearing loss persistent after treatment by PCP<br>2) Effusion persists more than 8 weeks |
| **UNILATERAL HEARING LOSS** | 1) Symptoms: difficulty hearing, or difficulty localizing sound, or problems hearing only in a crowded environment<br>2) Physical Examination: may be normal or may have cerumen or tympanic membrane abnormality | Referral for OTO-HNS evaluation is indicated in all cases of unilateral hearing loss, after vascular etiology ruled out, unless the problem resolves with elimination of cerumen |
| **Sudden Hearing Loss** | ***Loss of hearing with or without vertigo*** | ***Urgent referral to ENT*** if not resolved with cerumen removal<br>See above for Effusion |
| TINNITUS<br>1)Chronic bilateral<br>2)Unilateral or recent onset<br>3)Pulsatile | 1) Normal tympanic membranes or cerumen<br>2) Normal tympanic membranes or cerumen<br>3) Mass behind tympanic membrane? If positive, need CT temporal bones w/o contrast | 1) No referral indicated unless associated hearing loss, dizzy or unilateral Tinnitus.<br>2) If persists more than 8 weeks, Oto-HNS referral and hearing evaluation indicated |

| DIAGNOSIS | EVALUATION | CONDITIONS FOR REFERRAL |
|---|---|---|
| **DIZZINESS**<br>1)Orthostatic<br>2)Vestibular neuronitis<br>3)Chronic or episode | 1) Symptoms mild brief, only standing up (usually A.M.)<br>2) Associated with URI; may be positional or persisting<br>3) Significant imbalance and/or vertigo; may have associated hearing loss, tinnitus, ear pressure, nausea<br>4) If no hearing loss, ***pt must be referred for Balance Eval***, ***get VNG and Neurology Eval.*** if there is hearing loss, follow hearing loss guidelines | 1) ENT referral for vertigo (sensation of spinning) General dizziness needs work up with neurologist, cardiologist or PCP.<br>2) Associated hearing loss, vertigo increased severity or persistence > 6 weeks<br>3) ***Bring Balance Center Results, VNG Results and Neurology Evaluation Results NEEDED FOR REFERRAL*** |

**Skin Lesions of Head/Neck:** Dermal lesions are not contracted with ENTC

**Thyroid Mass:** Refer after ultrasound guided FNA results and endocrine evaluation completed.

Please refer the following conditions to the HPN contracted oral surgeon:

Gums /Floor of mouth

- Mandible
- Maxillary Bone