Clinical Prioritisation Criteria

Adult Ear Nose and Throat CPC V1.05

Summary

This document contains the draft Clinical Prioritisation Criteria (CPC) for Adult ear, nose and throat. It is a consultation document only. This is a drafting document and should be read in conjunction with the consultation overview.

The final format will be as indicated on the CPC website https://cpc.health.qld.gov.au/ and embedded into your local HealthPathways site or HHS site i.e. 'Refer your patient' website https://metrosouth.health.qld.gov.au/referrals or www.health.qld.gov.au/metronorth/refer.

For more information about the CPC development process and purpose, please see the accompanying CPC Consultation Overview.

Table of contents

Adult ear, nose and throat inclusion for outpatient services

The following conditions are proposed to be considered under the Adult ear, nose and throat CPC.

Please note this is not an exhaustive list of all conditions for outpatient services and does not exclude consideration for referral unless specifically stipulated in the CPC exclusions section.

Ear

- Ear drum perforation
- Chronic ear disease
- Tinnitus
- Dizziness/vertigo
- Hearing loss

Nose

- Acute nasal fracture
- Rhinosinusitis (acute)
- Rhinosinusitis (chronic/recurrent)
- Allergic rhinitis/nasal congestion/nasal obstruction
- Epistaxis – recurrent

Throat

- Tonsillitis
- Obstructive sleep apnoea
- Dysphagia
- Oropharyngeal lesions
- Dysphonia

Other

- Facial nerve palsy
- Thyroid mass
- Sialolithiasis (salivary stones)
- Salivary tumour

ENT Oncology

- Head and neck mass
- Primary parathyroid adenoma

Adult ear, nose and throat exclusions for outpatient services

Not all services are appropriate to be seen in the Queensland public health system. Exceptions can always be made where clinically indicated. It is proposed that the following are not routinely provided in a public adult ear, nose and throat service.

The following are not routinely provided in a public Adult ear, nose and throat service:

- Chronic bilateral tinnitus
  - Referral is not indicated unless tinnitus is disabling or associated with changes in hearing loss, aural fullness and/or discharge or vertigo
- Mild/brief orthostatic dizziness
- Hearing aid dispense (Hearing Service Program)
- Uncomplicated/chronic symmetrical hearing loss in over 70 years old
- Mild acute rhinosinusitis
- Aesthetic surgery

NB General Practitioners are able to directly refer patients to Queensland Health (QH) Audiologist. QH Audiologists are able to offer diagnostic hearing assessments which can result in a recommendation of hearing aids or an ENT opinion; however, they do not fit hearing aids. Queensland public hospitals **do not dispense** conventional or standard hearing aids. Patients with mild, moderate or severe hearing loss, which is symmetrical, should be referred to a local hearing aid provider. Hearing aids are provided for children, veterans, pensioners, ADF or NDIS participant with hearing needs through the Office of Hearing Services, a division of the Federal Department of Health and Ageing, and are dispensed by local audiologists

Referral and outpatient criteria

Ear drum perforation

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

•

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• Persistent discharge despite treatment and disabling pain and/or hearing loss significantly limiting quality of life, education, work • Recurrent episodes of discharging ear • Deteriorating hearing
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

1. **Reason for request,** indicate on the referral

- To establish a diagnosis
- For treatment or intervention not otherwise accessible to the patient
- For advice regarding management
- To engage in an ongoing shared care approach between primary and secondary care
- Reassurance for GP/second opinion
- Reassurance for the patient/family
- For other reason (e.g. rapidly accelerating disease progression)

2. **Essential referral information,** Referral will be returned without this

- Diagnostic audiology assessment (highly desirable where available and not cause significant delay)

3. **Additional referral information,** Useful for processing the referral

- Ear swab M/C/S results
- Results of Health Assessment for Aboriginal and/or Torres Strait Islander People

4. **Request**

General referral information/Standard information (Appendix 2, Consultation overview)

Notes

- Please note that where appropriate and where available, the referral may be streamed to an associated public allied health and/or nursing service. Access to some specific services may include initial assessment and management by associated public allied health and/or nursing, which may either facilitate or negate the need to see the public medical specialist.
- A change in patient circumstance (such as condition deteriorating or becoming pregnant) may affect the urgency categorisation and should be communicated as soon as possible.
- Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

5. **Other useful information for referring practitioners,** not an exhaustive list

Medical management:

- If ear discharge is present, swab for M/C/S
- Topical ear medication
- Antibiotics (eardrops or tablets)
- Analgesia

- Keep ear dry
- Review after three months by GP
- Arrange diagnostic audiological assessment

Clinical resources (links)	Patient resources (links)

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

- Ensure they are aware of the request and the reason for being assessed.
- Instruct them to take all relevant radiology films and reports (including the imaging report) to appointments.
- To advise of any change in circumstance (e.g., getting worse or becoming pregnant) as this may affect the request for assessment.

Chronic ear disease

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

-

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Discharging ear for longer than 3 months failing to settle with topical medication and new onset otalgia, headaches, vertigo (i.e. suspicious for cholesteatoma) and/or radiological confirmation of cholesteatoma (i.e. bony erosion reported)
Category 2 (appointment within 90 calendar days)	• Discharging ear for longer than 3 months failing to settle with topical medication • Imaging suggestive of possible cholesteatoma (i.e. no bony erosion reported)
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

1. **Reason for request,** indicate on the referral

- To establish a diagnosis
- For treatment or intervention not otherwise accessible to the patient
- For advice regarding management
- To engage in an ongoing shared care approach between primary and secondary care
- Reassurance for GP/second opinion
- Reassurance for the patient/family
- For other reason (e.g. rapidly accelerating disease progression)

2. **Essential referral information,** Referral will be returned without this

- Diagnostic audiology assessment (Highly desirable where available and not cause significant delay)

3. **Additional referral information,** Useful for processing the referral

- Ear swab M/C/S results
- Results of Health Assessment for Aboriginal and/or Torres Strait Islander People
- Fine cut/slice CT scan of temporal bone

4. **Request**

General referral information/Standard information (Appendix 2, Consultation overview)

Notes

- Please note that where appropriate and where available, the referral may be streamed to an associated public allied health and/or nursing service. Access to some specific services may include initial assessment and management by associated public allied health and/or nursing, which may either facilitate or negate the need to see the public medical specialist.
- A change in patient circumstance (such as condition deteriorating or becoming pregnant) may affect the urgency categorisation and should be communicated as soon as possible.
- Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

5. Other useful information for referring practitioners, not an exhaustive list

Medical management:

- If ear discharge is present, swab for M/C/S
- No irrigation of the ear
- Antibiotic ear drops
- Tragal pump technique
- Keep ear dry and tissue spearing prior to eardrops
- Analgesia
- Review at the end of treatment course by GP
- Arrange diagnostic audiological assessment
- Consider fine cut/slice CT scan of temporal bone to rule out extensive cholesteatoma

Clinical resources (links)	Patient resources (links)
Recommendations for clinical care guidelines on Management of OM in ATSI populations	QLD Primary Clinical Care Manual

Inform the patient

- Ensure they are aware of the request and the reason for being assessed.
- Instruct them to take all relevant radiology films and reports (including the imaging report) to appointments.
- To inform of any change in circumstance (e.g., getting worse or becoming pregnant) as this may affect the request for assessment.

Tinnitus

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

-

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Sudden onset or chronic unilateral tinnitus and any of the following: – vertigo – hearing loss – otalgia – otorrhoea • Sudden onset or chronic unilateral or bilateral pulsatile tinnitus or disabling tinnitus and any of the following: – vertigo – hearing loss

	– balance disturbance • Follow up of recent barotrauma event (air flight, diving or blast injury) • At the recommendation of local audiologist (highlighting the clinical concerns along with previous audiological report/results)
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	NB: Referral is not indicated unless tinnitus is disabling or associated with hearing loss, aural fullness and/or discharge or vertigo

1. Essential referral information, Referral will be returned without this

- Description of:
  - onset, duration frequency and quality
  - functional impact of tinnitus
  - any associated hearing/balance symptoms
  - any intervention and its effect
  - past history of middle ear disease/surgery
- Diagnostic audiology assessment (Highly desirable where available and not cause significant delay)

2. Additional referral information, Useful for processing the referral

- Private MRI with contrast to exclude acoustic neuroma in unilateral tinnitus
- Mechanism of injury (barotrauma)

3. Other useful information for referring practitioners, not an exhaustive list

- Patients with acute barotrauma should be sent to emergency
- If cerumen present, use dissolving drops and irrigation or suction if available
- Arrange diagnostic audiological assessment/tinnitus assessment
- Patient education/tinnitus management advice
- Consider private MRI with contrast to exclude acoustic neuroma in unilateral tinnitus
- Chronic tinnitus should not be referred to ENT unless associated with vertigo, hearing loss, otalgia, otorrhoea and balance disturbance.
- Chronic tinnitus - as above, and:
  - private audiology for masking hearing aid
  - consider cognitive behavioural therapy
  - private audiology for hearing aid if hearing loss present
  - public/private audiology for patient education/tinnitus management advice

Clinical resources (links)	Patient resources (links)

Dizziness/vertigo

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Sudden onset debilitating constant vertigo where the patient is very imbalanced (vestibular neuritis/stroke)
- Barotrauma with sudden onset vertigo

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• Benign Paroxysmal Positional Vertigo (BPPV) refractory to repeated canalith repositioning manoeuvres (> 3 treatments) • Co-morbid vestibular or otological conditions • Patients where particle repositioning is not advised due to limited range of movement in the neck, or due to general mobility issues that cannot be managed by a physiotherapist/ vestibular physiotherapist • Symptoms not resolved after seeing vestibular physiotherapist

1. Essential referral information, Referral will be returned without this

- Description of:
  - onset, duration, frequency and quality
  - functional impact of vertigo
  - any associated otological/neurological symptoms
  - any previous diagnosis of vertigo (attach correspondence)
  - any treatments (medication/other) previously tried, duration of trial and effect
  - any previous investigations/imaging results
  - hearing/balance symptoms
  - past history of middle ear disease/surgery
- Diagnostic audiology assessment (Highly desirable where available and not cause significant delay)

2. Additional referral information, Useful for processing the referral

- History of any of the following:
  - cardiovascular problems
  - neck problems
  - neurological
  - auto immune conditions
  - eye problems
  - previous head injury

3. Other useful information for referring practitioners, not an exhaustive list

- Exclude central cause of vertigo (cardiac/respiratory)
- Perform Hallpike test and Head Impulse Test (HIT) to determine likely cause of vertigo
- If BPPV likely based on symptoms and a positive Hallpike, then treat with canalith repositioning manoeuvre (Epleys or BBQ roll) and consider referral to a physiotherapist/vestibular physiotherapist

- If HIT positive with acute vertigo, consider vestibular neuritis
- Consider migraine associated vertigo and if appropriate management per local pathways
- Arrange diagnostic audiological assessment and/or vestibular testing
- Review of current medications
- Occupational therapy home assessment for falls prevention
- Consider advice regarding safe driving/licencing

Clinical resources (links)	Patient resources (links)

Hearing loss

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Sudden onset hearing loss in absence of clear aetiology and/or associated with vertigo and tinnitus

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Rapid progressive severe unilateral or bilateral sensorineural hearing loss and/or vertigo
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• Bilateral severe to profound hearing loss and any of the following: – poor speech discrimination – does not receive adequate benefit from hearing aids • Chronic hearing loss - change in symptoms or clinical findings

1. **Essential referral information,** Referral will be returned without this

- Description of:
  - hearing loss i.e. one or both sides
  - change in hearing loss
- Diagnostic audiology assessment (Highly desirable where available and not cause significant delay)

2. **Additional referral information,** Useful for processing the referral

- Information regarding any hearing aids or hearing devices and communication mode utilised by the patient e.g. Auslan
- Speech discrimination testing
- Any previous audiology assessment results

3. **Other useful information for referring practitioners,** not an exhaustive list

Medical management

- Cerumen dissolving drops and possible suction or irrigation
- Oral decongestant, Valsalva manoeuvres and re-evaluate after 3 weeks
- Arrange diagnostic audiological assessment
- For hearing aid wearers, refer to their local hearing aid provider to ensure optimal hearing aid fitting

Clinical resources (links)	Patient resources (links)

Nasal fracture (acute)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Acute nasal fracture with septal haematoma

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Acute nasal fracture requiring surgical intervention i.e. external bone displacement (best results for acute nasal fracture are achieved when patient is seen and managed within 2 weeks from time of injury) NB: Referrer contact needs to be made promptly by either emergency department referral or direct contact with the ENT service
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

1. Essential referral information, Referral will be returned without this

- Mechanism of injury

2. Additional referral information, Useful for processing the referral

- Advise anti-coagulation medication

3. Other useful information for referring practitioners, not an exhaustive list

- Exclude septal haematoma
- Cool compress to reduce swelling
- Analgesia
- Re-evaluate at 3-4 days to ensure nose looks normal and breathing is normal

Clinical resources (links)	Patient resources (links)

Rhinosinusitis (acute)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Acute bacterial rhinosinusitis - visual disturbance/signs, neurological signs/frontal swelling/severe unilateral or bilateral headache
- Unilateral facial swelling with or without dental sepsis

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

1. Essential referral information, Referral will be returned without this

2. Additional referral information, Useful for processing the referral

3. Other useful information for referring practitioners, not an exhaustive list

Clinical resources (links)	Patient resources (links)

Rhinosinusitis (chronic/recurrent)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Acute bacterial rhinosinusitis - visual disturbance/signs, neurological signs/frontal swelling/severe unilateral or bilateral headache

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• Chronic and recurrent: persistent symptoms > 8 weeks, and/or > 3 episodes per year • Failed/not responding to maximal medical management

	• Complicated sinus disease (extra sinus extension, suggestive of fungal disease)

1. Essential referral information, Referral will be returned without this

- Frequency of episodes
- Details of previous treatment (including systemic and topical medications prescribed) including the course and outcome of the treatment
- CT para nasal sinuses post full course of medical management

2. Additional referral information, Useful for processing the referral

- No additional information

3. Other useful information for referring practitioners, not an exhaustive list

Medical management:

- Treat any acute bacterial infection appropriately (10-day course of Augmentin duo forte) Avoid all penicillins if allergic
- 5 days only of BD nasal decongestant spray e.g. oxymetazoline at the start of the course
- 3 months of:
  - oral roxithromycin 300mg daily
  - intra nasal steroid spray e.g. mometasone BD for 2 weeks, then nocte thereafter
  - intra nasal saline rinse/irrigation (not spray) BD-TDS
- If rhinorrhoea is the predominant symptom add either atrovent spray or second-generation antihistamine
- Consider short course of oral corticosteroid therapy
- If symptoms persist at close of treatment, consider CT para nasal sinuses
- Analgesia
- Manage environmental factors:
  - co-existing allergies
  - discuss contribution of smoking
- Discuss role of environmental and household pollutants (wood/coal smoke, incense, perfumes, chlorine)

Clinical resources (links)	Patient resources (links)

Allergic rhinitis/nasal congestion/obstruction

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

•

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Nasal obstruction (polyps) and any of the following: – Unilateral – offensive or bloody discharge
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within	• Nasal obstruction (polyps) and any of the following: – Bilateral

365 calendar days)	– Persisting polyps despite preliminary course of oral steroids with at least 8 weeks of topical intranasal corticosteroid • Allergic Rhinitis – Failed/not responding to maximal medical management • Nasal obstruction and any of the following: – Post trauma – deviated nasal septum – concha bullosa where surgical management is indicated

1. Essential referral information, Referral will be returned without this

- Details of previous treatment (including systemic and topical medications prescribed) including the course and outcome of the treatment

2. Additional referral information, Useful for processing the referral

- CT scan paranasal sinuses results
- Skin prick/RAST/IgE results (Allergic rhinitis)

3. Other useful information for referring practitioners, not an exhaustive list

Medical management for sinonasal inflammation:

- 2-month course of:
  - Intra nasal mometasone BD for 2 weeks, then nocte thereafter
  - 5 days only of BD nasal decongestant spray e.g. oxymetazoline at the start of the course
- BD-TDS saline rinse/irrigation
- Manage any co-existing allergies
- Patient education

Consider the following:

- CT scan paranasal sinuses
- Short course of oral corticosteroid therapy
- Skin prick testing/RAST/IgE (Allergic rhinitis)

Clinical resources (links)	Patient resources (links)

Epistaxis –recurrent

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Severe or persistent epistaxis

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Recurrent epistaxis with no obvious cause • Associated change in sense of smell, • Epiphora • Diplopia
Category 2	• No category 2 criteria

(appointment within 90 calendar days)	
Category 3 (appointment within 365 calendar days)	• Recurrent epistaxis on a background of nasal trauma

1. Essential referral information, Referral will be returned without this

- Details of previous treatment (including systemic and topical medications prescribed) including the course and outcome of the treatment
- Current medication list including any NSAIDS, aspirin or warfarin, anti-platelets plus NOACs and anti-hypertensive medication
- Coagulopathy/platelet disorder screening results

2. Additional referral information, Useful for processing the referral

- No additional information

3. Other useful information for referring practitioners, not an exhaustive list

Medical management:

- Investigations of coagulopathy, platelet disorder and/or hypertension
- Hypertension management
- Pressure on the nostrils (> 5mins)
- If bleed is visible in Little's area consider cautery with silver nitrate (after applying topical anaesthesia)
- Intranasal packing coated with antibiotic ointment

Clinical resources (links)	Patient resources (links)

Tonsillitis (recurrent) or tonsillar enlargement

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Acute tonsillitis with airway obstruction and/or unable to tolerate oral intake and/or uncontrolled fever
- Tonsillar haemorrhage
- Abscess or haematoma, (e.g. peritonsillar abscess/quinsy, salivary abscess, septal or auricular haematoma, paranasal sinus pyocele) with or without associated cellulitis

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• Chronic or recurrent infection with fever/malaise and decreased PO intake: – 4 or more episodes in the last 12 months – 6 or more episodes in the last 24 months – sleep apnoea due to tonsillar hypertrophy – tonsillar concretions with halitosis

	– absent from work/university/college for 4 weeks in a year

1. Essential referral information, Referral will be returned without this

- The number and timeframe of previous episodes
- The degree of systemic upset
- Previous antibiotic prescriptions
- Details of previous treatment (including systemic and topical medications prescribed) including the course and outcome of the treatment
- Please advise if taking any anticoagulant medication, including aspirin and fish oil, and any family history of coagulation disorder in referral

2. Additional referral information, Useful for processing the referral

- Has tonsillitis caused an admission to hospital in the previous 12 months?

3. Other useful information for referring practitioners, not an exhaustive list

Medical management

- Manage acute episodes
- Analgesia
- Antibiotics
- Fluids
- Throat gargle
- Rest
- Consider monospot test for glandular fever

Clinical resources (links)	Patient resources (links)

Obstructive sleep apnoea (ENT)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

-

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• Upper airway obstruction due to tonsillar hypertrophy • Moderate to severe symptoms (e.g. Epworth Sleepiness Scale > 15) and a positive sleep study • Failure of CPAP therapy due to patient anatomical factors e.g. nasal obstruction/deviated septum, tongue size/upper airway anatomy, mandibular anatomy

1. Essential referral information, Referral will be returned without this

- Epworth Sleepiness Scale results

2. Additional referral information, Useful for processing the referral

- Recent polysomnography (PSG) results
- BMI

3. Other useful information for referring practitioners, not an exhaustive list

Medical management

- Long-term intranasal steroids (mometasone) if no contraindications
- Manage allergies
- If BMI > 30 manage weight loss
- Epworth Sleepiness Scale
- Consider Sleep Studies for evaluation, PSG and consideration/trial of CPAP
- If patient has an under bite, refer to a dentist for a mandibular advancement splint

Clinical resources (links)	Patient resources (links)

Dysphagia (ENT)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Complete dysphagia
- Superglititis

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Suspicion of oropharyngeal lesion - dysphagia and any of the following: – new onset of hoarseness – unilateral otalgia – progressive weight loss – smoking history – excessive alcohol intake • Significant stenotic/dysphagic symptoms particularly if progression of the symptoms and may include any of the following: – gagging, choking, and/or coughing when swallowing – food or liquids coming back up to throat, mouth, and/or nose after swallowing – feel like foods or liquids are stuck in throat or chest or problems getting food or liquids to go down on the first attempt – oropharyngeal pain or referred pain to ear when swallowing – pain or pressure in chest or heartburn – weight loss/loss of appetite/food avoidance – shortness of breath post eating (in absence of other cause) • Recurrent chest infections (aspiration pneumonia)
Category 2 (appointment within 90 calendar days)	• No category 2 criteria

Category 3 (appointment within 365 calendar days)	• No category 3 criteria

1. Essential referral information, Referral will be returned without this

- Neurology history (ie stroke's, progressive neurological disease)
- Previous history head/neck oncological treatment

2. Additional referral information, Useful for processing the referral

- Barium swallow or Modified Barium Swallow results
- CT neck and chest (with contrast) results
- CXR results
- TSH results

3. Other useful information for referring practitioners, not an exhaustive list

Consider the following:

- TSH
- Speech pathology referral for swallowing assessment if concerned about dysphagic symptoms

Clinical resources (links)	Patient resources (links)

Oropharyngeal lesions

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

•

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Suspicious oropharyngeal (lip, tongue, hard/soft palate, uvula, floor of mouth) lesion or mass with any of the following: – leukoplakia – ulceration – pain – bleeding – discharge • Non-healing oropharynx ulcer for > 4 weeks
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

1. Essential referral information, Referral will be returned without this

- General referral information

2. Additional referral information, Useful for processing the referral

- History of smoking/chewing tobacco/chewing beetle nut/alcohol/any sharp chipped teeth

• FBC results
3. Other useful information for referring practitioners, not an exhaustive list
• Please do not perform biopsy or FNA • If bleeding significant, check FBC

Clinical resources (links)	Patient resources (links)

Dysphonia

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

•

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Recent change to voice and persistent hoarseness which fails to resolve in 4 weeks and may include a background history of any of the following: – history of smoking – excessive alcohol intake – recent intubation – recent cardiac/thyroid/carotid/cervical spine interventions
Category 2 (appointment within 90 calendar days)	• Recurrent episodes of hoarseness altered voice in patient with no other risk factors for malignancy
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

1. Essential referral information, Referral will be returned without this
• Neurology history
2. Additional referral information, Useful for processing the referral
• Speech pathology assessment results • Medication history
3. Other useful information for referring practitioners, not an exhaustive list
Consider the following: • Diabetes, gastroesophageal reflux, hypothyroidism, oropharyngeal tumours, lung lesion, recurrent laryngeal nerve damage or chronic rhinosinusitis if indicated • Speech pathology assessment if concern about voice quality

Clinical resources (links)	Patient resources (links)

Facial nerve palsy

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

-

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Lower motor neuron palsy and any of the following: – hearing loss – suspected other cranial nerve involvement • Lower motor neuron palsy and otalgia and/or otorrhoea • Vesicles in tympanic membrane and otalgia and/or otorrhoea • Perineural spread from cutaneous SCC with or without sensory changes e.g. tingling, numbness, formiculation
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

1. Essential referral information, Referral will be returned without this

- Neurology/neurosurgery history
- Details of previous treatment (including systemic and topical medications prescribed) including the course and outcome of the treatment
- Diagnostic audiology assessment (Highly desirable where available and not cause significant delay)

2. Additional referral information, Useful for processing the referral

- Fine cut/slice CT scan of temporal bone results

3. Other useful information for referring practitioners, not an exhaustive list

Medical management

- Oral steroids 1mg daily for 5 days
- Consider oral anti virals if indicative of Ramsay Hunt syndrome
- Eye protection from corneal abrasion e.g. lacrilube and tape eye shut nocte
- Consider speech pathology assessment if speech and/or swallowing affected
- Arrange diagnostic audiological assessment
- If facial palsy with otalgia and/or otorrhoea, consider fine cut/slice CT scan of temporal bone to rule out cholesteatoma

Clinical resources (links)	Patient resources (links)

Thyroid mass

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

-

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Cytology confirmed malignancy or suspicious FNA or dominant nodule > 4cm on USS • Compressive symptoms e.g. dyspnoea, hoarseness or dysphagia
Category 2 (appointment within 90 calendar days)	• Generalised thyroid enlargement without compressive symptoms or • Recurrent thyroid cysts
Category 3 (appointment within 365 calendar days)	• Surveillance of known benign thyroid lumps > 40mm in diameter

Please add any additional criteria

1. Essential referral information, Referral will be returned without this

- USS +/- FNA results
- TSH and T4 results

2. Additional referral information, Useful for processing the referral

- No additional information

3. Other useful information for referring practitioners, not an exhaustive list

Consider the following:

- USS +/- FNA
- TSH and T4
- Speech pathology referral for swallowing assessment if concerned about dysphagic or dysphonic symptoms

Clinical resources (links)	Patient resources (links)

Sialolithiasis (salivary stones)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

-

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Acute salivary gland inflammation which fails to respond to oral antibiotics within 1 week
Category 2 (appointment within	• No category 2 criteria

90 calendar days)	
Category 3 (appointment within 365 calendar days)	• Symptomatic salivary stones and/or recurrent symptoms that fail to respond to non-invasive treatment

1. Essential referral information, Referral will be returned without this

- XR or USS results

2. Additional referral information, Useful for processing the referral

- M/C/S results

3. Other useful information for referring practitioners, not an exhaustive list

Non-invasive management of small stones:

- Hydration, moist heat therapy, NSAIDs, have the patient take citrus fruits to promote salivation/ spontaneous expulsion of stone
- Consider XR or USS
- Consider M/C/S

Clinical resources (links)	Patient resources (links)

Salivary tumour

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Confirmed or suspected tumour or hard mass in the salivary glands
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• Pleomorphic adenoma's that have been previously investigated and are not growing.

1. Essential referral information, Referral will be returned without this

- USS +/- CT results

2. Additional referral information, Useful for processing the referral

- FNA results

3. Other useful information for referring practitioners, not an exhaustive list

Consider the following:

- USS +/- CT
- FNA

Clinical resources (links)	Patient resources (links)

Head and neck mass

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Confirmed head and neck malignancy • Suspicious solid and/or cystic neck lumps > 6 any of the following: – history of smoking – history of excessive alcohol intake – previous head/neck malignancy
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

1. Essential referral information, Referral will be returned without this

- USS +/- CT neck results
- ELFT, FBC, ESR results

2. Additional referral information, Useful for processing the referral

- CT chest +/- FNA results

3. Other useful information for referring practitioners, not an exhaustive list

Consider the following:

- CT or USS of neck, CT chest +/- FNA
- Blood tests ELFT FBC ESR

Clinical resources (links)	Patient resources (links)

Primary parathyroid adenoma

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Primary parathyroid adenoma identified on imaging with raised serum calcium and/or raised PTH
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within	• No category 3 criteria

365 calendar days)	

1. Essential referral information, Referral will be returned without this

- ELFT FBC results
- Serum calcium and PTH results
- Thyroid/parathyroid USS results

2. Additional referral information, Useful for processing the referral

- Sestamibi parathyroid scintigraphy results

3. Other useful information for referring practitioners, not an exhaustive list

NB If imaging results are not suggestive of a primary parathyroid adenoma, refer to endocrinology

Clinical resources (links)	Patient resources (links)

Other referrals to emergency not covered within these conditions

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

EAR

- ENT conditions with associated neurological signs
- Sudden onset facial weakness
- Foreign body
- Complicated mastoiditis/cholesteatoma or sinusitis (periorbital cellulitis, frontal sinusitis with persistent frontal headache)
- Ear canal oedema/unable to clear discharge
- Trauma

NOSE

- Acute bacterial rhinosinusitis - visual disturbance/signs, neurological signs/frontal swelling/severe unilateral or bilateral headache
- Unilateral facial swelling with or without dental sepsis

THROAT

- Airway compromise- stridor/drooling breathing difficulty/acute or sudden voice change/severe odynophagia
- Ludwig's angina
- Acute hoarseness associated with neck trauma or surgery
- Laryngeal obstruction and/or fracture
- Pharyngeal/laryngeal foreign body
- Accidental dislodgement or obstruction of permanent tracheostomy
- New onset of bleeding or shrinkage of laryngectomy stoma
- Abscess or haematoma, (e.g. peritonsillar abscess/quinsy, salivary abscess, septal or auricular haematoma, paranasal sinus pyocele) with or without associated cellulitis

Intervention criteria

Out-of-scope for Adult ear, nose and throat interventions

Not all services are funded in the Queensland public health system. Exceptions can always be made where clinically indicated. It is proposed that the following are not routinely provided in a public Adult ear, nose and throat service:

- Cosmetic rhinoplasty

Urgency category for intervention

Intervention	Minimum criteria	Urgency
Ethmoidectomy		3
Functional endoscopic sinus surgery		3
Laryngectomy		1
Mastoidectomy		3
Microlaryngoscopy		2
Myringoplasty/ tympanoplasty		3
Myringotomy		3
Nasal cautery		3
Nasal polypectomy		3
Panendoscopy		1
Parotidectomy/submandibular gland- excision of		2
Pharyngoplasty		3
Pharynx- excision of		1
Rhinoplasty (for reasons other than cosmetic)		3
Septoplasty		3
Stapedectomy		3
Sub-mucosal resection		3
Tonsillectomy (+/- adenoidectomy)		3
Turbinectomy		3

.

Version control

Version	Date	Author	Nature of amendment
v0.1-v0.4		Bernard Whitfield, Nicole Mitchell and Kelly Reeves	CAG consultation
V0.5	19/11/2015	Bernard Whitfield, Nicole Mitchell and Kelly Reeves	Out for stage 1 consultation
V0.6-v0.9		Bernard Whitfield, Nicole Mitchell and Kelly Reeves	Amendments following stage 1 consultation and desktop audit
V0.10	21/04/2016	Nicole Mitchell and Kelly Reeves	Transfer into 'phase 2' consultation template and editorial review
V1.0	20/05/2016	Nicole Mitchell and Kelly Reeves	Final endorsed CPC
V1.01	06/07/2017	CPC Team (Liz Travers)	Rebranding and amendments from CPC website/implementation of CPC
V1.02	26/6/2018	CPC Team (Liz Travers	Template for review of CPC
V1.03	18/7/2018	CPC Team (Liz Travers) and CAG	CAG review meeting 18/7/2018. Amendments made
V1.04	25/7/2018	CPC Team (Liz Travers)	Amendments post CAG meeting – for distribution to CAG
V1.05	20/8/2018	CPC Team (Liz Travers) and CAG	Further amendments Tinnitus and Salivary tumour.
V1.06	25/9/2018	CPC team (Katie Wykes)	Preparation for statewide consultation