Clinical Prioritisation Criteria

Paediatric ENT CPC v1.03

Summary

This document contains the draft Clinical Prioritisation Criteria (CPC) for **Paediatric ENT CPC**. 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.

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Paediatric ENT inclusion for outpatient services

The following conditions are proposed to be considered under the **Paediatric ENT 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

- Hearing loss
- Otitis externa
- Otitis media – acute suppurative otitis media (ASOM)
- Otitis media – with effusion (OME or glue ear)
- Perforated ear drum/chronic suppurative otitis media (CSOM)

NOSE

- Nasal fracture (acute)
- Epistaxis (recurrent)
- Nasal allergic rhinitis/congestion/obstruction

THROAT

- Dysphonia/hoarseness
- Tonsillitis (recurrent)
- Sleep disordered breathing/obstructive sleep apnoea
- Stridor
- Neck mass

Paediatric ENT 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 **Paediatric ENT** service.

The following are not routinely provided in a public paediatric ENT service.

- Mild acute rhinosinusitis
- Simple ear drum perforation as a part of acute otitis media

Referral and outpatient criteria

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.

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Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• Recently diagnosed unilateral/bilateral sensorineural hearing loss (SNHL) or congenital hearing loss • Confirmed structural damage • Hearing loss in the setting of speech delay or educational handicap • Hearing loss requiring hearing aid authorisation
Category 3 (appointment within 365 calendar days)	• Recent diagnosis of unilateral/bilateral conductive hearing loss

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

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

3. Additional referral information, Useful for processing the referral

- No additional information

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

- General practitioners are able to directly refer patients to Queensland Health (QH) audiologists. 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 and pensioners through the Office of Hearing Services, a division of the Australian Government Department of Health, and are dispensed by local audiologists.

- Arrange diagnostic audiology assessment.
- Consider referral to speech pathology or child health clinician for developmental speech and language screening in children
- Refer to HealthPathways or local guidelines

Clinical resources (links)	Patient resources (links)

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.

Otitis externa

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.

- Otitis externa with uncontrolled pain and/or cellulitis extending beyond the ear canal and/or ear canal is swollen shut

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Confirmed otitis externa and persistent symptoms/pain and hearing loss despite maximal medical management
Category 2 (appointment within 90 calendar days)	• Confirmed otitis externa without pain • Associated dermatitis
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

- General referral information

3. Additional referral information, Useful for processing the referral

- Ear swab M/C/S results

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

- Refer to HealthPathways or local guidelines
- An ear wick should be inserted when the ear canal is very oedematous (to maintain patency of the ear canal and allow topical drops to enter the ear canal) and moistened frequently with topical drops
- If child wears a hearing aid, consider impact of the condition on the ability to wear the device
- Avoid syringing
- If ear discharge is present, swab for M/C/S
- Topical antibiotics if associated infection
- Treat with topical agents and ear toilet if available and as appropriate

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 inform of any change in circumstance (e.g., getting worse or becoming pregnant) as this may affect the request for assessment.

Otitis media - acute otitis media with or without perforation (AOMwiP/AWMwioP)

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.

- Any suspicions of the complications of ASOM ie Mastoiditis (proptosis of pinna), meningitis etc

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• Suspicion of complicated otitis media e.g. cholesteatoma and/or • Painful discharging ears despite topical antibiotic (first line) and/or PO antibiotic therapy (second line) for 5 days • Children with physical/structural/ medical comorbidities e.g. cleft palate, craniofacial abnormalities, diabetes, SNHL
Category 3 (appointment within 365 calendar days)	• ASOM with ear drum perforation with persisting concerns > 6 weeks and/or • Recurrent AOM (rAOM) More than 3 episodes of acute otitis media in 6 months or

	• Recurrent AOM (rAOM) More than 4 episodes of acute otitis media in a 12-month period

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

- Medical management to date

3. Additional referral information, Useful for processing the referral

- Duration of condition and antibiotic use to treat condition
- Ear swab M/C/S results
- Diagnostic audiology assessment results (Highly desirable where available and not cause significant delay)
- 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

- Refer to HealthPathways or local guidelines
- If ear discharge is present, swab for M/C/S
- Adequate analgesia
- If child wears a hearing aid, consider impact of the condition on the ability to wear the device
- Antibiotics if less than 6 months old, high risk population group or failure to improve in 24 hours < 2 years old, or failure to improve in 48 hours in > 2 years old
- Consider diagnostic audiology assessment if ongoing episodes (Highly desirable where available and not cause significant delay)

Clinical resources (links)	Patient resources (links)
Recommendations for clinical care guidelines on the management of Otitis Media in Aboriginal and Torres strait Islander populations (2010) https://www.health.gov.au/internet/main/publishing.nsf/Content/B8A6602C7714B46FCA257EC300837185/%24File/Recommendation-for-clinical-guidelines-Otitis-Media.pdf	Care for kids ears http://www.careforkidsears.health.gov.au/internet/cfke/publishing.nsf CHQ Deadly Ears Program https://www.childrens.health.qld.gov.au/chq/our-services/community-health-services/deadly-ears/resources/

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.

Otitis media – with effusion (OME or glue ear)

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.

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Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• Confirmed or suspected structural damage to the tympanic membrane e.g. significant retraction, cholesteatoma and/or • Effusion – in the setting of speech delay or educational handicap and/or – lasting more than 3 months with audiometry showing significant bilateral conductive hearing loss (45dB or greater better ear) • Children with physical/structural/ medical comorbidities e.g. cleft palate, craniofacial abnormalities, diabetes, SNHL
Category 3 (appointment within 365 calendar days)	• Effusion lasting more than 3 months with audiometry showing mild bilateral conductive hearing loss (20-45dB better ear) • Unsteady gait/balance problems • Glue ear for 3 months with mild HL

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

- General referral information

2. Additional referral information, Useful for processing the referral

- Diagnostic audiology assessment results (Highly desirable where available and not cause significant delay)
- Results of Health Assessment for Aboriginal and/or Torres Strait Islander People

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

- Refer to HealthPathways or local guidelines
- Antihistamines, decongestants and antibiotics have no beneficial effect in the management of otitis media with effusion (OME)
- Review at 3 months for persistent middle ear effusion or hearing loss
- If child wears a hearing aid, consider impact of the condition on the ability to wear the device
- Consider speech pathology for language assessment
- Management of environmental factors
- Arrange diagnostic audiology assessment (Highly desirable where available and not cause significant delay)

Clinical resources (links) **Patient resources (links)**

Recommendations for clinical care guidelines on the management of Otitis Media in Aboriginal and Torres strait Islander populations (2010) https://www.health.gov.au/internet/main/publishing.nsf/Content/B8A6602C7714B46FCA257EC300837185/%24File/Recommendation-for-clinical-guidelines-Otitis-Media.pdf	

Perforated eardrum/chronic suppurative otitis media (CSOM)

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.

- Trauma
- New onset facial nerve palsy

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• Perforated tympanic membrane and – ongoing pain and/or – persistent drainage from the middle ear for > 6 weeks despite topical antibiotics and/or – significant hearing loss 45dB or greater better ear • Children with physical/structural/ medical comorbidities e.g. cleft palate, craniofacial abnormalities, diabetes, SNHL
Category 3 (appointment within 365 calendar days)	• Failure of dry perforation to heal after 2 months or • All non-acute long-term perforated ear drums or • Bilateral dry perforation with mild hearing loss and no pain

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

- Medical management to date

2. Additional referral information, Useful for processing the referral

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

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

- Refer to HealthPathways or local guidelines
- If ear discharge is present, swab for M/C/S
- Antibiotic therapy – topical ciprofloxacin (first line) and/or oral antibiotic (if systemic infection)
- If child wears a hearing aid, consider impact of the condition on the ability to wear the device
- Arrange diagnostic audiology assessment
- Keep ear dry

• Education of caregivers on cleaning of ear canal by tissue spearing or dry mopping prior to antibiotic drops

Clinical resources (links)	Patient resources (links)
Recommendations for clinical care guidelines on the management of Otitis Media in Aboriginal and Torres strait Islander populations (2010) https://www.health.gov.au/internet/main/publishing.nsf/Content/B8A6602C7714B46FCA257EC300837185/%24File/Recommendation-for-clinical-guidelines-Otitis-Media.pdf	

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.

- Trauma with other associated injuries i.e. other facial fractures e.g. orbit

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 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

- No additional information

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

- Refer to HealthPathways or local guidelines
- No requirement for XR for simple nasal fractures. May require imaging if other facial fractures suspected.
- Exclude septal haematoma
- Cool compress to reduce swelling
- Analgesia

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
- Septal haematoma

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Epistaxis with suspicion of a tumour
Category 2 (appointment within 90 calendar days)	• Unilateral epistaxis in adolescent male/ suspicion of juvenile nasopharyngeal angiofibroma (JNA)
Category 3 (appointment within 365 calendar days)	• Epistaxis not responding to maximal medical management for > 6 to 8 weeks e.g. topical creams, no nose picking, manage allergic rhinitis

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

- Medical management to date

2. Additional referral information, Useful for processing the referral

- FBC, Coag result including Von Willebrand screening if suspected blood dyscrasia

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

- Refer to HealthPathways or local guidelines
- Trial of steroid ointment/ or general moisturising ointment to anterior septum twice a day for at least 6 to 8 weeks
- FBC Coag result including Von Willebrand screening if suspected blood dyscrasia

Clinical resources (links)	Patient resources (links)

Nasal allergic rhinitis/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.

- Foreign body (button batteries). If suspicion of button battery immediate emergency review.

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Unilateral nasal obstruction with offensive and/or bloody discharge
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• Nasal obstruction – failed maximal medical management and/or

	– septal deviation causing symptomatic nasal obstruction • Allergic Rhinitis • failed maximal medical management (see 'other useful information for referring practitioners' section)

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

- Medical management to date

2. Additional referral information, Useful for processing the referral

- RAST/IgE results (allergic rhinitis)

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

- Refer to HealthPathways or local guidelines

Medical management:

- Treat any acute bacterial infection
- Saline rinse/irrigation
- Manage co-existing allergies and environmental factors
- Topical steroid nasal sprays for perennial and seasonal allergic rhinitis/perennial non-allergic rhinitis (8 weeks minimum trial, safe for long term treatment
- Seasonal rhinitis - commence spray 1 month prior to relevant pollen season and continue over the symptomatic period
- Antihistamines - do not use as first line treatment but may be used for seasonal rhinitis
- Consider assessment by an allergy specialist and allergy testing

Clinical resources (links)	Patient resources (links)

Dysphonia/hoarseness

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.

- If new onset hoarse voice and any airway obstructive symptoms

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• > 1 month of moderate to severe hoarseness and voice loss • Suspicion of: – papilloma – thrush – vocal cord palsy
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

- Speech pathology assessment results

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

- Refer to HealthPathways or local guidelines
- Treat laryngitis
- Promote voice hygiene
- Refer to speech pathology
- Voice quality assessment GRBAS (Grade (severity), Roughness, Breathy voice, Asthenia (weakness) and Strain)

Clinical resources (links)	Patient resources (links)

Tonsillitis – 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.

- Abscess or haematoma (e.g. peritonsillar, parapharyngeal (quinsy), salivary, neck or retropharyngeal abscess)
- Post-tonsillectomy haemorrhage

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• Ulceration and/or recurrent unilateral enlargement, with/without lymphadenopathy
Category 3 (appointment within 365 calendar days)	• Recurrent sore throat due to acute tonsillitis: – 4 or more episodes in the last 12 months, *or* – 4 episodes per year for 2 consecutive years, *or* – 3 episodes per year for 3 consecutive years, *or* – more than 2 weeks missed for school or parent's attendance at work *or* – history of quinsy

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
- Medical management to date

2. Additional referral information, Useful for processing the referral

- EBV serology/monospot results
- FBC results

3. **Other useful information for referring practitioners,** not an exhaustive list	
• Refer to HealthPathways or local guidelines	
Clinical resources (links)	**Patient resources (links)**

Sleep disordered breathing/obstructive sleep apnoea

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)	• Severe obstructive sleep apnoea proven on paediatric polysomnography and/or overnight pulse oximetry • Obstructive sleep apnoea with failure to thrive
Category 3 (appointment within 365 calendar days)	• Sleep disordered breathing: – nasal obstruction and snoring and/or suspicion of sleep apnoea and/or – adenotonsillar obstruction and snoring and/or suspicion of sleep apnoea

1. **Essential referral information,** Referral will be returned without this
• General referral information
2. Additional referral information, Useful for processing the referral
• Tonsillar hypertrophy grading scale • Obstructive sleep apnoea with co-existing craniofacial abnormality • Paediatric Epworth/pictorial Sleepiness Scale • Recent paediatric polysomnography
3. Other useful information for referring practitioners, not an exhaustive list
• Refer to HealthPathways or local guidelines • Long-term intranasal steroids • Manage allergies • Weight loss • Paediatric Epworth/pictorial Sleepiness Scale

Clinical resources (links)	**Patient resources (links)**

Stridor

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.

- Airway compromise: severe stridor/drooling/ breathing difficulty/acute, sudden voice change/ severe odynophagia

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Moderate non-life-threatening stridor with feeding difficulties
Category 2 (appointment within 90 calendar days)	• Mild non-life-threatening stridor without feeding difficulties
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

- Feeding quality

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

- Refer to HealthPathways or local guidelines
- For stand-alone feeding difficulties (no stridor) consider referral to speech pathology

Clinical resources (links)	Patient resources (links)

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.

- Acutely enlarging neck mass with any associated airway symptoms e.g. stridor, drooling, dysphagia etc

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Neck mass that: – is increasing in size and/or – does not respond to antibiotics and/or – persists for > 6 weeks
Category 2 (appointment within 90 calendar days)	• Suspected thyroid mass or • All other neck masses
Category 3 (appointment within	• No category 3 criteria

365 calendar days)	

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

- USS neck results

2. Additional referral information, Useful for processing the referral

- TSH result
- ELFT FBC results

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

- Refer to HealthPathways or local guidelines
- No CT scan required

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

- Foreign body
- Trauma
- ENT conditions with associated neurological signs e.g. facial nerve palsy, profound vertigo and/or sudden deterioration in sensorineural hearing
- Acute and/or complicated mastoiditis
- Auricular haematoma

NOSE

- Foreign body (button batteries)
- Periorbital cellulitis with or without swelling with or without sinusitis

THROAT

- Foreign body (button batteries – inhaled or ingested)
- Trauma
- Hoarseness associated with neck trauma or surgery

Intervention criteria

Out-of-scope for Paediatric ENT 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 Paediatric ENT service.

- Cosmetic surgery

Urgency category for intervention

Intervention	Minimum criteria	Urgency
Adenoidectomy without tonsillectomy	Otitis media with effusion or nasal congestion with or without rhinitis	3
Bronchoscopy with dilation		1
Cauterisation or diathermy of nasal turbinates		3
Closed reduction of fracture of nasal bone		1
Ear toilet, bilateral		1
Excision of rim of perorated tympanic membrane		3
Functional rhinoplasty		3
Implantation of cochlear prosthetic device	Post-meningitis infection	1
Implantation of cochlear prosthetic device	Bilateral hearing loss meeting criteria for cochlear implantation	2
Implantation of cochlear prosthetic device	Single-sided deafness	3
Implantation of middle ear and/or bone anchored implant		2
Laryngoscopy		2
Microlaryngoscopy		2
Microlaryngoscopy with removal of lesion by laser		2
Myringoplasty, postural or endaural approach		3
Myringoplasty, transcanal approach		3
Myringotomy with insertion of tube, bilateral		3
Myringotomy with insertion of tube, unilateral		3
Otoplasty		3
Removal of foreign body from auditory canal without incision		1
Tonsillectomy with adenoidectomy		3
Tonsillectomy without adenoidectomy		3
Grommets	Significant hearing loss (45dB or greater better ear) confirmed on two audiograms 3 months apart and/or significant retraction	2
Grommets	Mild hearing loss (20-45 dB better ear) confirmed on two audiograms 3 months apart	3

	and/or significant retraction	

Version control

Version	Date	Author	Nature of amendment
v0.01	18/09/2015	Nicole Mitchell and Dr Rob Black	Initial version
v0.02	30/10/2015	Nicole Mitchell and Dr Rob Black	Update following round 1 CAG consultation
v0.03	13/11/2015	Nicole Mitchell, Dr Rob Black, Dr Bernard Whitfield and Kelly Reeves	Update following round 2 CAG consultations
v0.4	04/12/2015	Nicole Mitchell, Dr Rob Black and Kelly Reeves	Updated following Stage 1 consultation
v0.5	20/04/2016	Nicole Mitchell, Dr Rob Black and Kelly Reeves	Updated following late feedback
V1.0	23/05/2016	Nicole Mitchell, Dr Rob Black and Kelly Reeves	Minor editorial amendments to be consistent with CPC wording e.g. addition of 'medical management to date'
V1.1	27/07/2017	CPC Team (Liz Travers)	Rebranding and inclusions of amendments from feedback 1/7/16-30/6/17
V1.2	20/6/2018	CPC Team (Liz Travers)	Commencement of CPC review
V1.3	4/9/2018	CPC Team (Liz Travers)	Amendments from Dr N Slee. Prep for broader consultation.