

ENT Emergencies

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Epistaxis

- Risk assessment
- Stopping the bleeding
- Looking at the nose
- Disposition

Epistaxis

- Risk assessment
 - ABC
 - Blood loss so far
 - Potential for ongoing blood loss
 - Ability to cope with blood loss

Epistaxis

- How do you assess blood loss?
 - Clinical signs of shock
 - Clinical signs of anaemia (how long has it gone on?)
 - Role of initial Hb

Epistaxis

- **Who will continue to lose blood?**
 - Bleeds that are hard to stop!
 - Weird anatomy (post surgical, malignant, congenital)
 - Bad clotting
 - Non-compliant patients
 - Part of multi-system illness or trauma

Epistaxis

- Who will fail to cope with blood loss?
 - Cardiac disease
 - Pulmonary disease
 - Bone marrow disease

Epistaxis

- Morphine
 - What???
 - Three roles
 - Invariably anxious
 - Packing is uncomfortable
 - BP is often very high which makes haemostasis hard

Epistaxis

- **Haematology**

- Platelets less than 50000 will probably need topping up
 - Risk of TRALI and bacterial contamination
- WARFARIN needs reversal
- Clopidogrel and Digabatrin are a problem
- Aspirin- effect wanes after about 24-48 hours so withhold until pack out

Epistaxis



Child sits in adults lap



© Kids Health Info
RCH, Melbourne

Epistaxis



Epistaxis



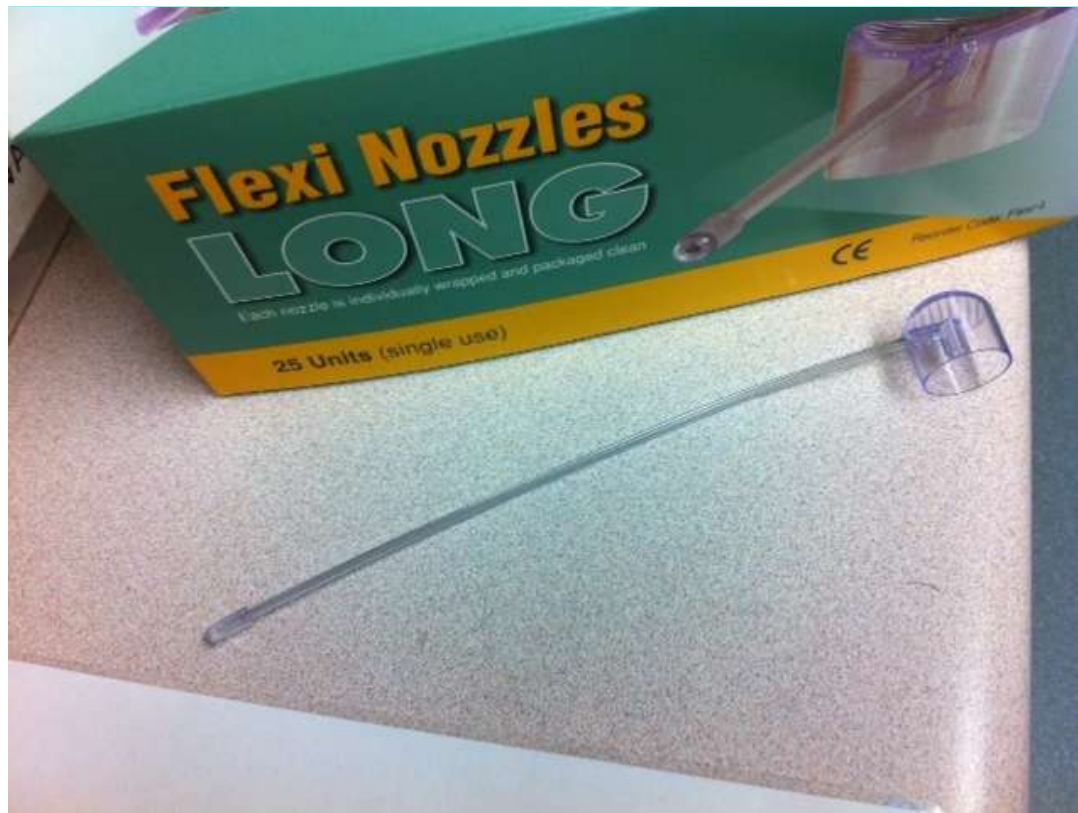
Epistaxis



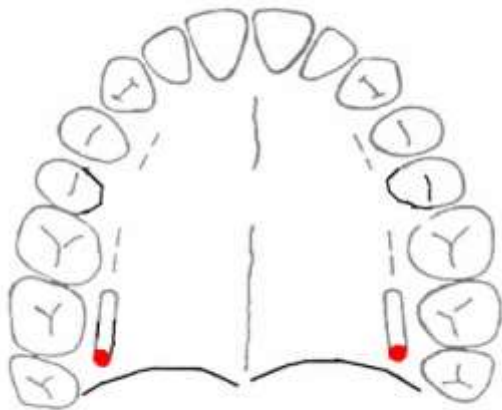
Epistaxis



Epistaxis



Epistaxis



- **Greater palatine foramen**
 - Local anaesthetic with adrenaline may be introduced here to assist with vasoconstriction in Little's area
 - Bent 25G needle
 - Bleb in roof of mouth
 - Find foramen with needle and inject

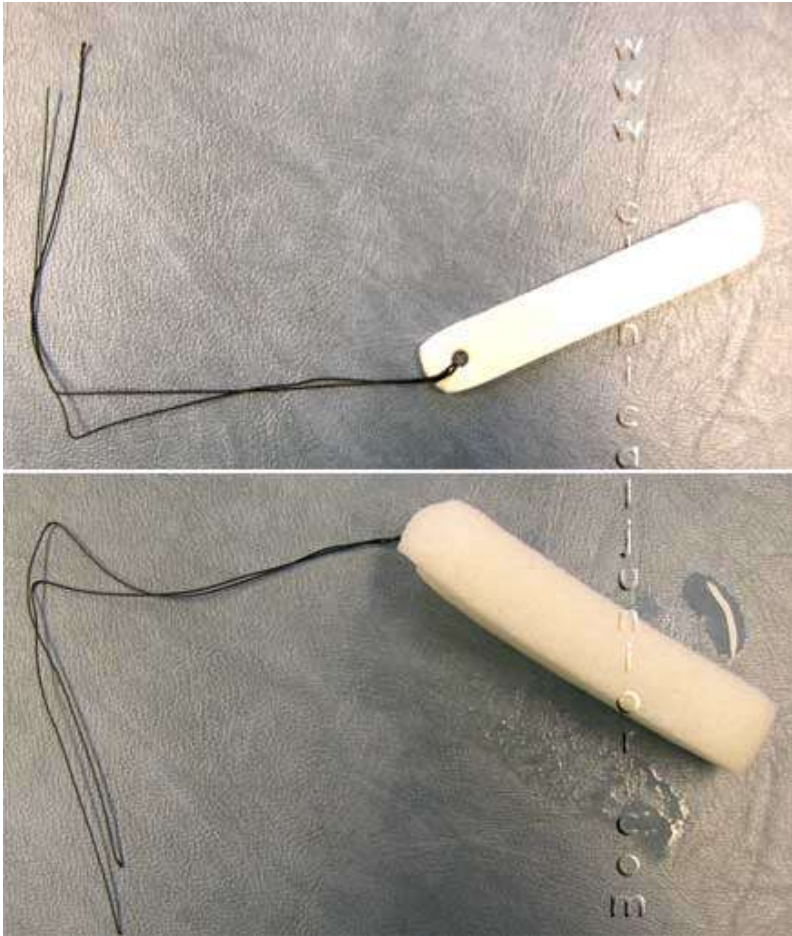
Epistaxis



Epistaxis



Epistaxis



- Merocel before and after wetting
 - Thanks to www.clinicaljunior.com for the pic

Epistaxis



- **Rapid Rhino**
 - Soak 30sec in WATER to activate the lubricant coating
 - Slide it in
 - Inflate with 5-7mL of AIR
 - Anterior version has only one balloon. This one has two for posterior bleeds

Epistaxis

- Disposition

- ADMIT

- In an big hospital you need to convince an ENT registrar to admit the patient which is hard.
 - In a small hospital you may be able to admit them under yourself
 - Bendigo SSOU has a pathway for epistaxis.

Epistaxis

- Disposition
 - SSOU
 - Recheck Hb in the morning
 - Ensure no bleeding overnight
 - Consider removing pack and watch for further bleeding

Nasty ENT infections

- Quinsy
 - Usually mistaken for tonsillitis for a while
 - Unilateral (look for deviated uvula)
 - Not much exudate
 - Trismus is common (responds to good analgesia)
 - Will not resolve without drainage

Nasty ENT infections

- **Bacterial tracheitis**
 - Usually kids a bit too old for croup
 - Presents a bit like croup but more toxic looking
 - Won't swallow, flex/ext neck
 - Often not keen to lie flat
 - Tender swelling along trachea
 - Treat with IV antis and involve paediatrics and ICU

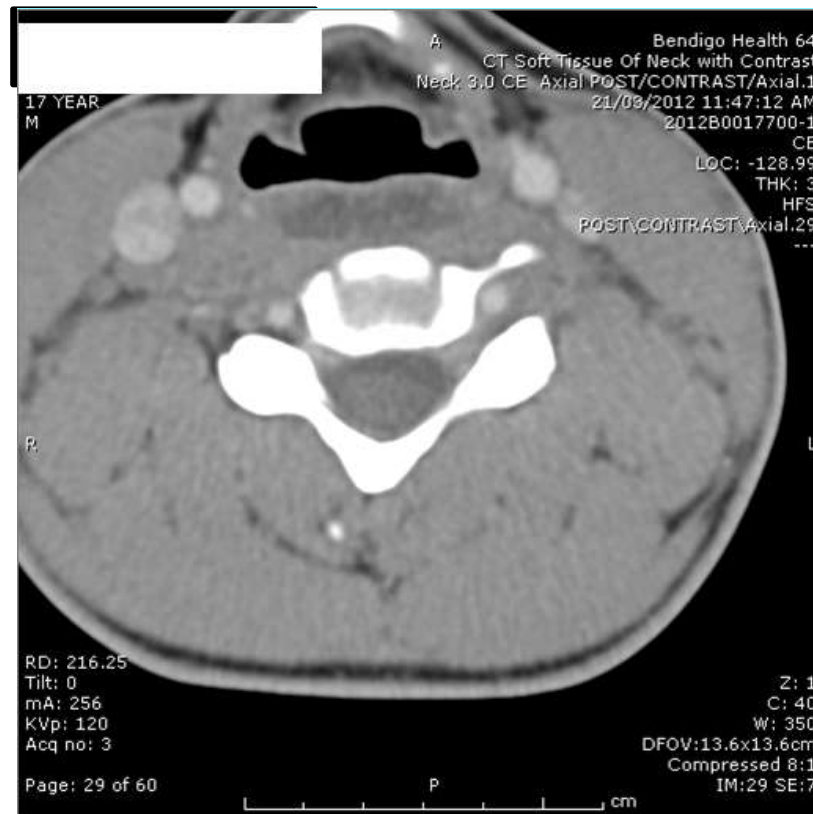
Nasty ENT infections

- **Retropharyngeal abscess**
 - Sore neck but often posterior or lateral. May have seen physio/chiropractor already
 - Fever (at some point)
 - Can't swallow
 - Voice normal but uncomfortable
 - Normal tonsils

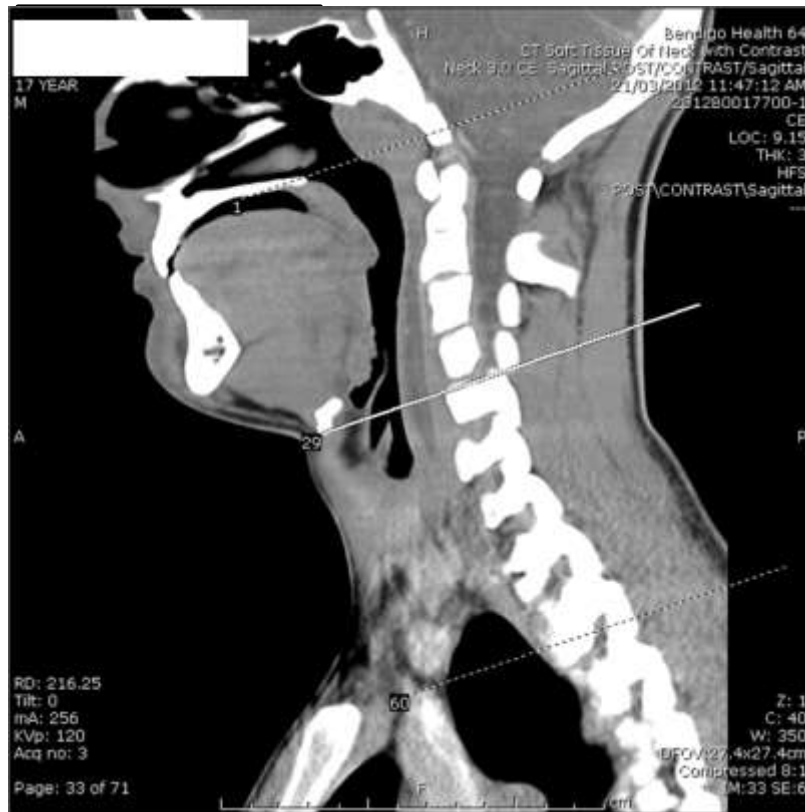
Nasty ENT infections



Nasty ENT infections



Nasty ENT infections



Nasty ENT infections

- Epiglottitis
 - No longer a paediatric emergency nightmare since Hib vax
 - Mostly in adults now
 - Non-typable haemophilus
 - Viruses
 - May be hard to differentiate from laryngitis
 - Sore throat, hoarse voice, fever

Nasty ENT infections

- Epiglottitis
 - Stridor, can't lie flat are critical warning signs
 - Lateral neck Xray might help

Nasty ENT infections

Thumbprint sign



Normal



Nasty ENT infections

- **Management**

- Always assume airway at risk
- If airway to be managed assume it will be difficult to impossible. GET HELP.
- Treat with IV Abs
- Get surgical input. Quinsy & retropharyngeal abscess need drainage. Tracheitis and Epiglottitis may need primary surgical airway.