

CASE PRESENTATIONS OF COMMON ENT DISORDERS

Rebecca Stone, M.D.



- Will cover common ENT problems
- One less common that is interesting

PCPS WILL SEE THESE THE MOST!

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- ▶ Covid -19 pounds!
- ▶ Increasingly waking up spouse
- ▶ Mouth breathing
- ▶ Excessively tired during the day

SNORING



Epworth Sleepiness Scale (ESS)

Situation	Chance of dozing (0–3)			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place—for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
Total Score				

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Johns MW. *Sleep*. 1991;14:540.

HOME SLEEP STUDY

- ▶ More deep night sleep
- ▶ May underestimate #hours sleep (falsely lower AHI)
- ▶ Patients generally prefer

IN-LAB POLYSOMNOGRAPHY

- ▶ Better to diagnose parasomnias
- ▶ Can be done if former negative and suspicion is high or patient prefers (and insurance covers)

SLEEP STUDY OPTIONS



- ▶ HST: AHI 6, supine 9, non -
supine 3.4
- ▶ No desats on HST
- ▶ Bed partner annoyed but
generally well rested.

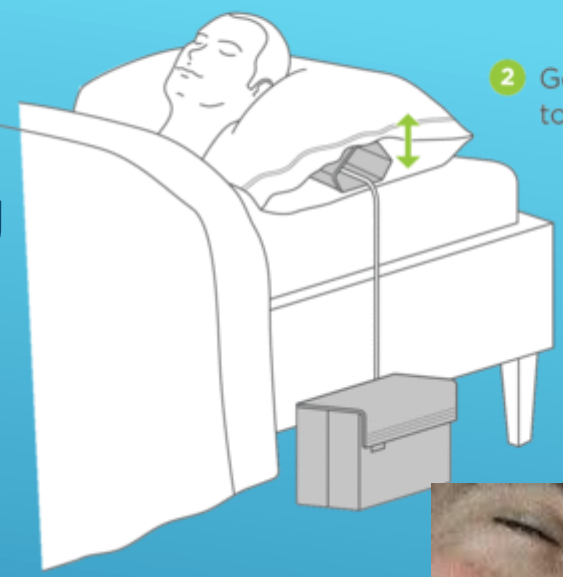
PATIENT: 37 YO MAN, BMI 30

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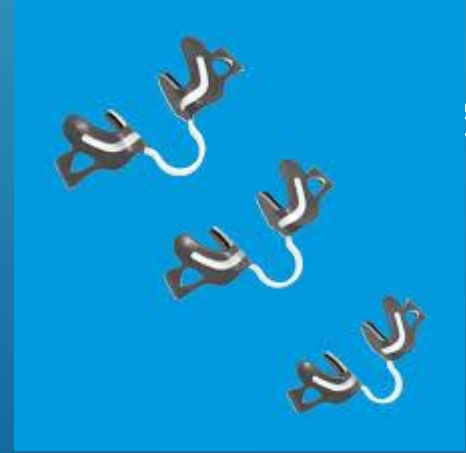


1 Detects snoring

2 Gently moves your pillow to interrupt snoring.



- ▶ Ear plugs
- ▶ Body positioning (tennis ball trick, pillows)
- ▶ Nasal strips, nasal cones, nasal breathing inserts
- ▶ Smart Nora
- ▶ Weight loss
- ▶ Out of pocket – dental appliance, CPAP etc
- ▶ Mouth taping?

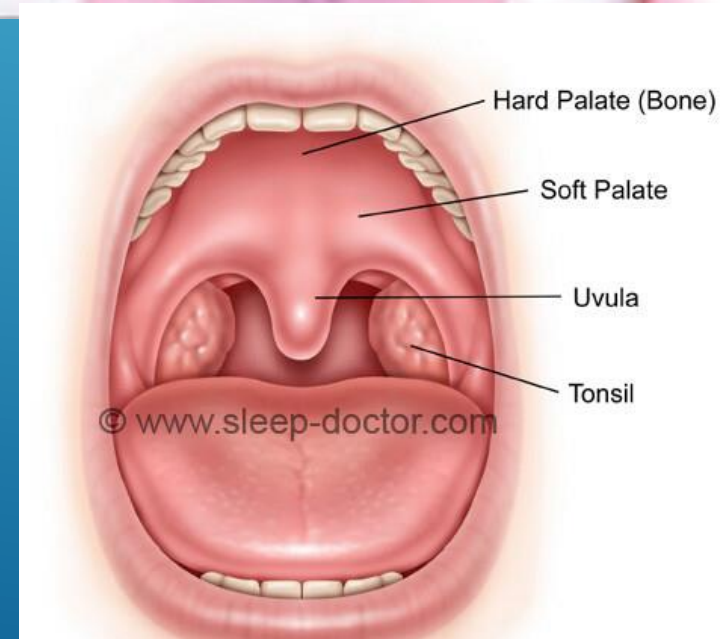


SNORING ONLY

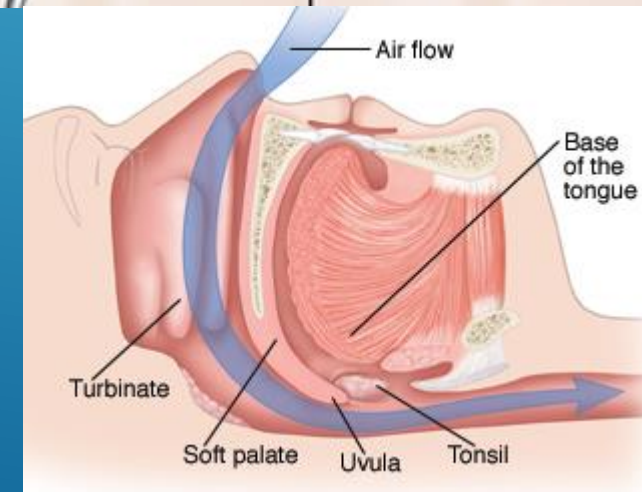
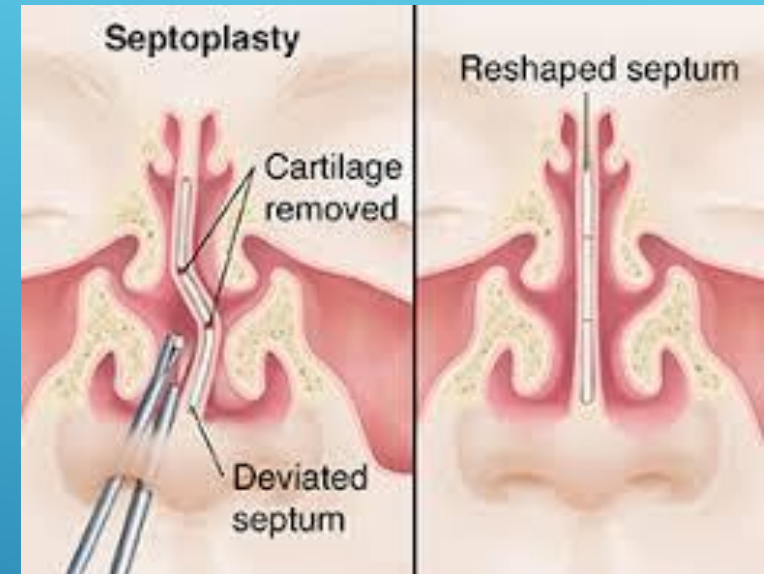
- ▶ HST: AHI 14, supine 18, non supine 10



PATIENT: 22 YO F BMI 29



- ▶ AHI 5-15, no huge desats
- ▶ Optimize nasal cavity – here, could be a role for septoplasty and turbinate reduction as treatment option (no more than 15% drop AHI but improved RDI)
- ▶ Body positioning, weight loss
- ▶ Option for CPAP/dental appliance
- ▶ Option for intracapsular tonsillectomy in select few
- ▶ Mouth taping?

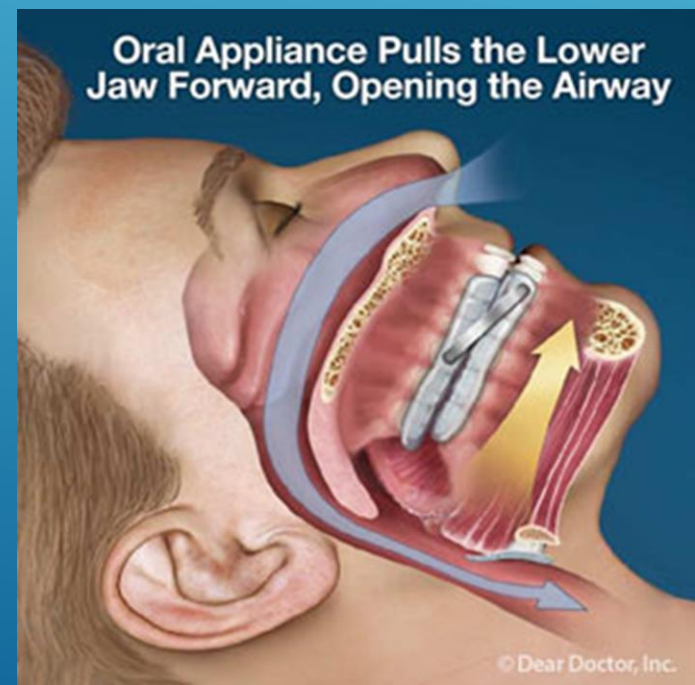


MILD OSA

- ▶ AHI 15-25, AHI 25-65+, +/- desats
- ▶ Optimize nasal cavity but will never be curative, so only to help tolerate other treatments
- ▶ CPAP = gold standard
- ▶ Dental appliance option
- ▶ Medical weight loss- GLP-1 agonists indicated for obesity with associated morbidities like OSA

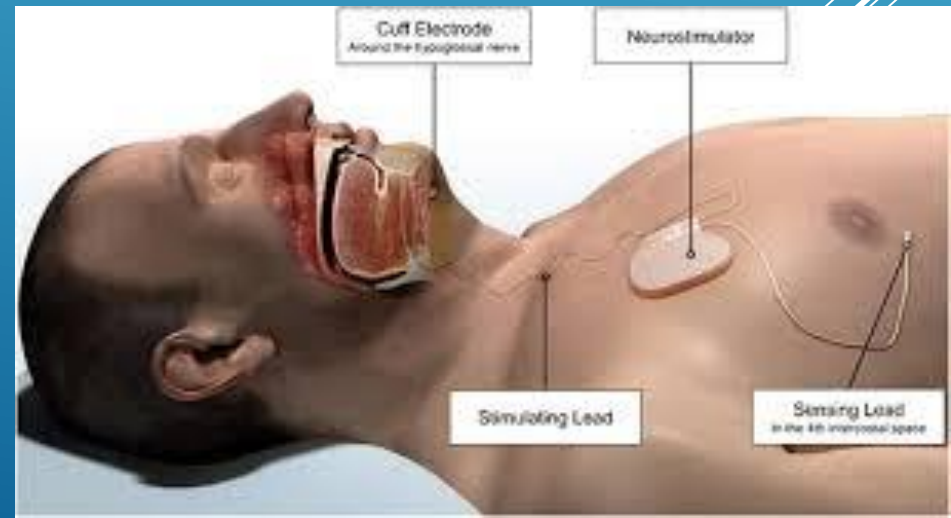
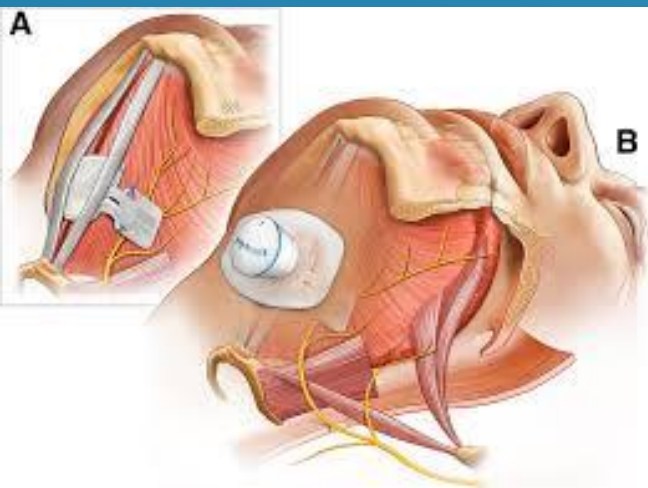


MODERATE- SEVERE OSA

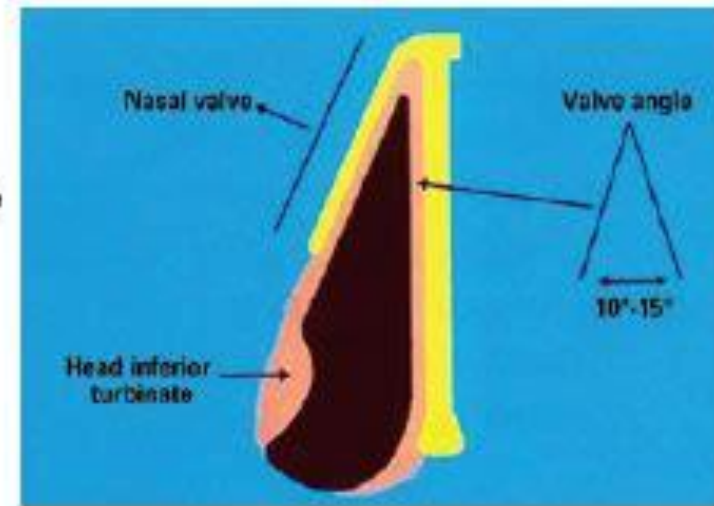


- Hypoglossal nerve stimulator (BMI<35, age> 18)-Inspire is one, others entering market
- Requires Drug Induced Sleep Endoscopy to assess candidacy
- Sensor in chest determines when pulse generated to push tongue forward, others using biphasic pulse generation or incision under chin to genioglossus muscle

SURGICAL TREATMENT MODERATE TO SEVERE OSA



- ▶ Septal deviation/septal swell body
- ▶ Inferior turbinate hypertrophy
- ▶ Lateral nasal wall angle/collapsibility



“I CAN'T BREATHE OUT
OF MY NOSE”

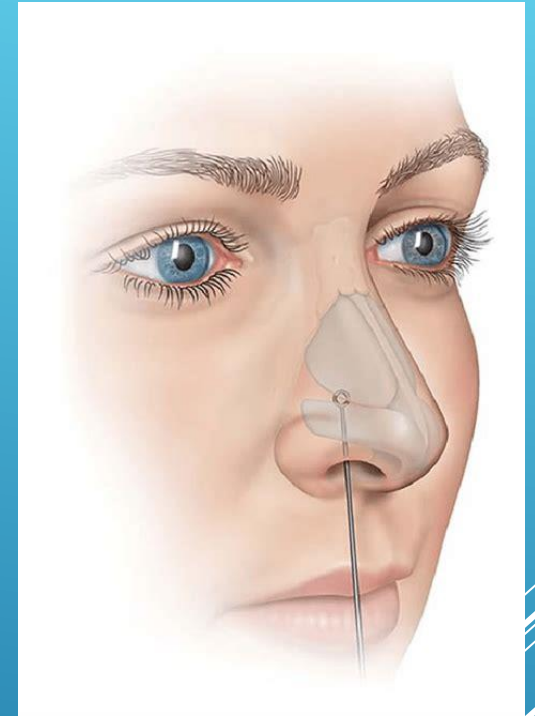


SURGICAL PATIENT?



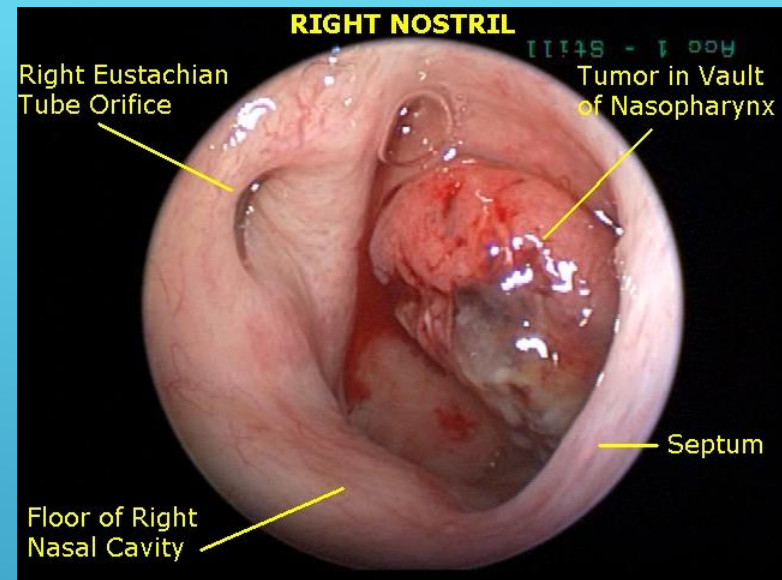
- ▶ Allergy evaluation (RAST vs skin testing)
- ▶ Smoking cessation/control of LPR
- ▶ Imaging if polyps/evidence of CRS
- ▶ Septoplasty/turbinate reduction
address cross sectional airway but
not dynamic piece

DIAGNOSTIC CONSIDERATIONS
(AFTER CAREFUL HISTORY AND
PHYSICAL EXAM, INCLUDING
ENDOSCOPY)



- ▶ Sino-nasal eg polyps
- ▶ Choanae- eg atresia
- ▶ Nasopharynx- eg adenoid hypertrophy, nasopharyngeal carcinoma
- ▶ Trauma/Iatrogenic

NASAL OBSTRUCTION CAUSES

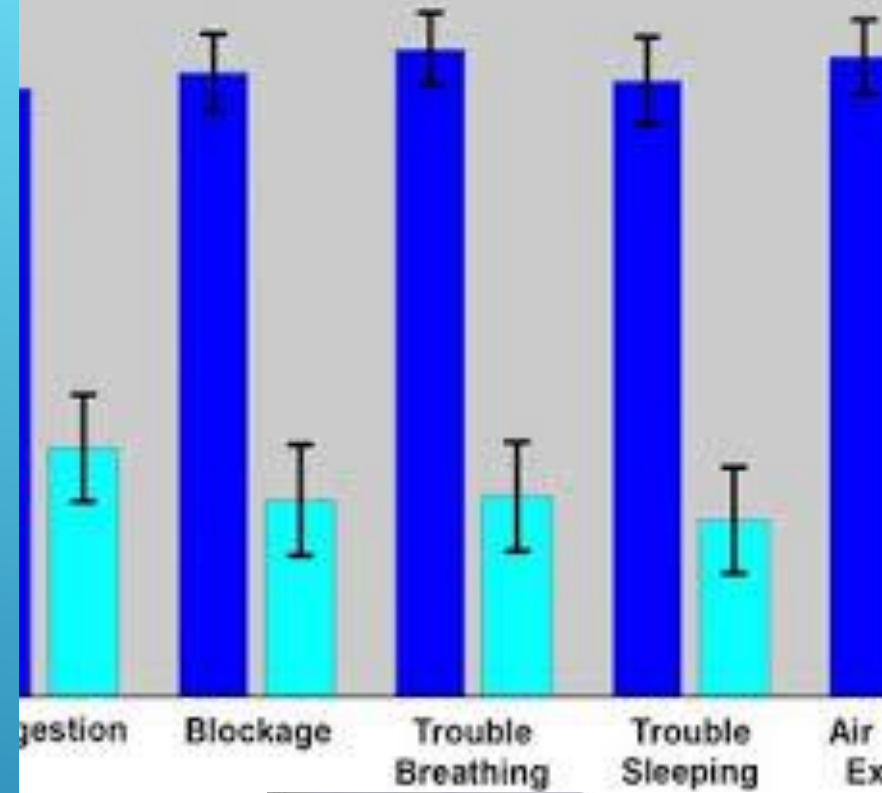


- ▶ Steroid nasal spray
- ▶ Prednisone
 - ▶ “medical polypectomy”
- ▶ Management of allergy- consideration of oral or intranasal antihistamine, avoidance and even immunotherapy
- ▶ Modulating injectables- Dupilumab, Omalizumab, and Mepolizumab

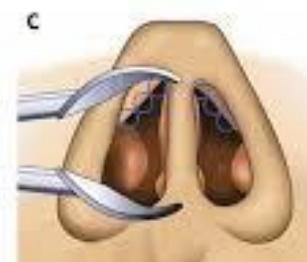
MEDICAL TREATMENT



- ▶ Radiofrequency ablation/modification- can address all three area
- ▶ Coblation of turbinates
- ▶ Nasal valve implants



OTHER PROCEDURAL OPTIONS FOR NASAL OBSTRUCTION



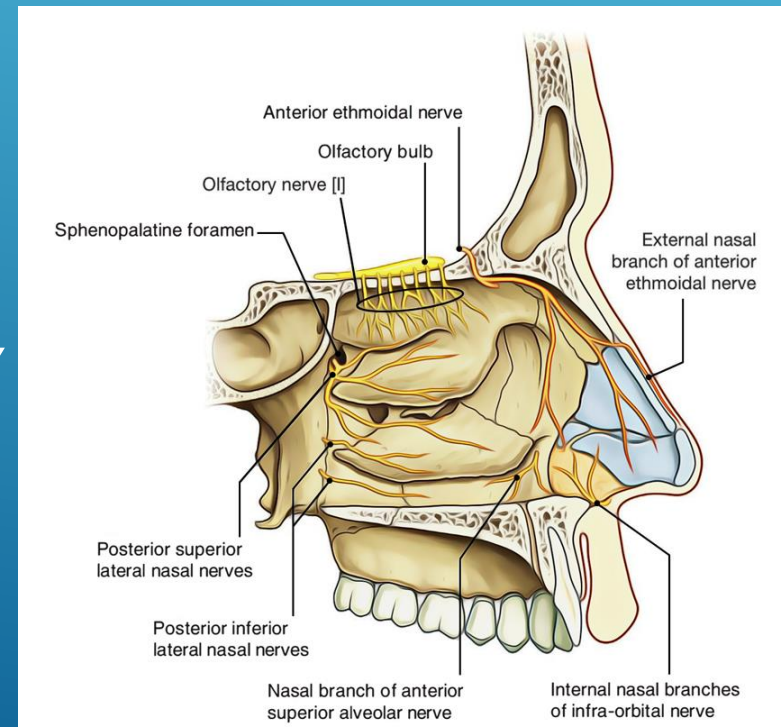
- ▶ 87 yo woman whose nose runs constantly
- ▶ Minor congestion
- ▶ No allergy history, nor c/o sneezy, itchy etc
- ▶ “Like a faucet doesn’t shut off”
- ▶ The tissue sign

THE DRIPPY NOSE



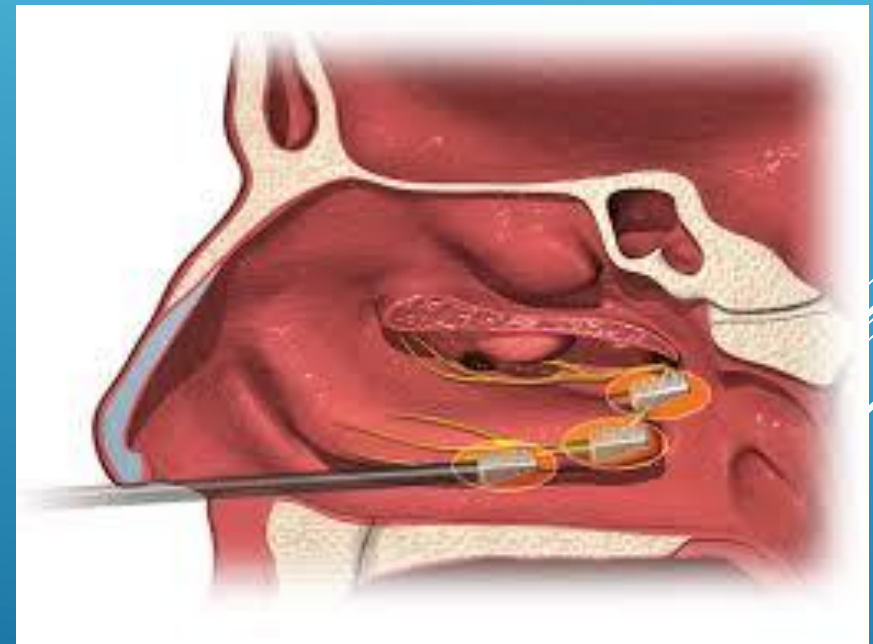
- ▶ Cold chemoreceptors (trigeminal branches) regulate nasal patency
- ▶ Swelling of tissue to cold is contrary to typical extremity vasoconstriction
- Nasal cycle
- Autonomic innervation nasal cavity

NASAL PHYSIOLOGY



- ▶ Medical: ipratropium bromide nasal spray
- ▶ Surgical options: ablation of posterior nasal nerve- cryotherapy vs radiofrequency

TREATMENT OPTIONS



TNSS	Likert SCALE: 0—No Symptoms; 1—Mild Symptoms; 2—Moderate Symptoms; 3—Severe Symptoms			
Nasal Congestion	0	1	2	3
Sneezing	0	1	2	3
Rhinorrhea	0	1	2	3
Nasal Itching	0	1	2	3

TOTAL NASAL SYMPTOMS SCORE

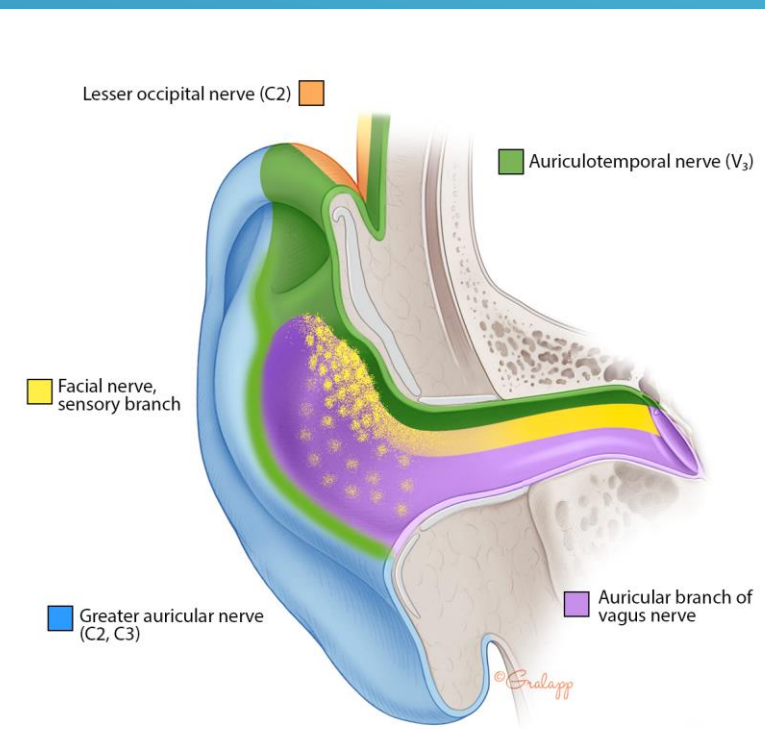
- ▶ 31 yo mother of two with left > right ear ache
- ▶ Started after the election
- ▶ No change in hearing, drainage, or ear history

EAR PAIN



- ▶ Exam: normal ear canal, tympanic membrane, and tuning forks
- ▶ Evidence of bruxism, mildly asymmetry opening of jaw
- ▶ Secondary otalgia more common in adults
- ▶ Consider laryngoscopy
- ▶ Consider other secondary causes including dental origin

NOT FROM THE EAR



- ▶ TMJD affects 6-9% of adults, 2nd only to low back pain for chronic pain
- ▶ May present with headaches, earache, clicking, popping, or crackling sounds in the temporomandibular joint, and impaired mandibular function

TMJD



- ▶ Soft diet
- ▶ Warm compresses
- ▶ Avoid gum chewing
- ▶ NSAIDS (oral or topical)
- ▶ Dental evaluation (nightguard?)
- ▶ If more chronic consider CBT, massage/PT with jaw stretching/trigger point/exercises, acupuncture
- ▶ Always important to re-evaluate/refer if not improving as referred pain can rarely be presentation of malignancy in head and neck

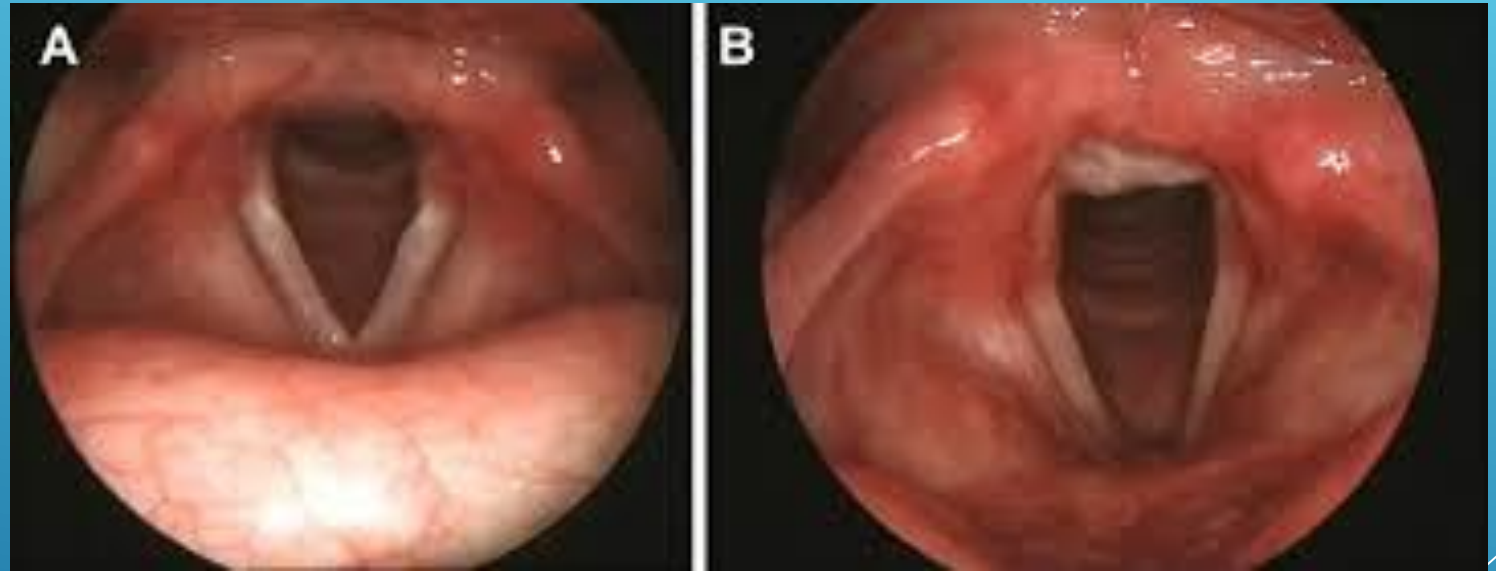
TMJD TREATMENT

- ▶ 49 yo man with sense of lump in throat
- ▶ 6 weeks in duration, constant sense of need to clear, sometimes excess clear mucous
- ▶ Mild morning hoarseness
- ▶ Effortful swallow
- ▶ No pain, difficulty swallowing or weight loss

GLOBUS SENSATION



- ▶ Evaluation should include laryngoscopy if symptoms are persistent for > 4 weeks



PHYSICAL EXAM

- ▶ LPR
- ▶ Posterior rhinorrhea
- ▶ Chronic sinusitis
- ▶ Laryngitis sicca
- ▶ Laryngeal lesions- cancer, polyps
- ▶ Laryngeal neuropathy

DIFFERENTIAL DIAGNOSIS

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- ▶ 15% of ENT patients will have, up to 50% of those with voice/laryngeal complaints based on dual pH probe testing
- ▶ 2/3 will not experience classic GERD
- ▶ Composite score of symptoms may be more accurate
- ▶ Non acid reflux like bile more difficult to test

LARYNGOPHARYNGEAL REFLUX (LPR)

Reflux Symptom Index

Within the last MONTH, how did the following problems affect you?

0 = no problem, 5 = severe problem

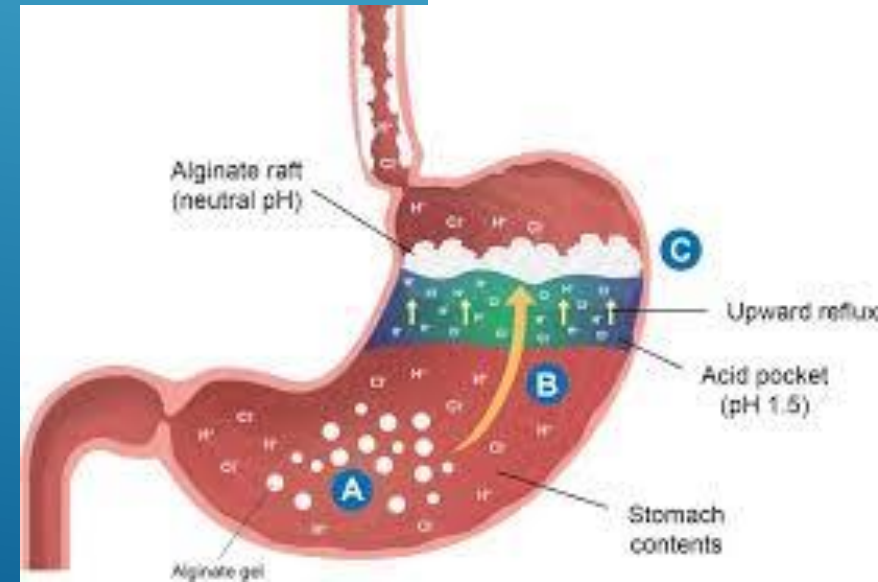
1. Hoarseness or a problem with your voice	0 1 2 3 4 5
2. Clearing your throat	0 1 2 3 4 5
3. Excess throat mucous or postnasal drip	0 1 2 3 4 5
4. Difficulty swallowing food, liquids, or pills	0 1 2 3 4 5
5. Coughing after you ate or after lying down	0 1 2 3 4 5
6. Breathing difficulties or choking episodes	0 1 2 3 4 5
7. Troublesome or annoying cough	0 1 2 3 4 5
8. Sensations of something sticking in your throat or a lump in your throat	0 1 2 3 4 5
9. Heartburn, chest pain, indigestion, or stomach acid coming up	0 1 2 3 4 5
Total	

Source: Center for Voice Disorders of Wake Forest University. Reprinted with permission.

- ▶ Diet and lifestyle changes e.g. no eating < 3 hrs before bed, upright after eating, avoiding fatty/rich foods
- ▶ Classic rx: up to BID PPI x 8 weeks
- ▶ H2 blockers, alginates
- ▶ Consideration of GI consult, surgical and non surgical LES treatments
- ▶ Speech language pathology
- ▶ Long term discussions



TREATMENT



- ▶ 85 year old woman fall onto face
- ▶ Or 20 yo man took an elbow to face playing basketball
- ▶ Bleeding from nose ensued
- ▶ Now congestion and “doesn’t look right”

NASAL TRAUMA



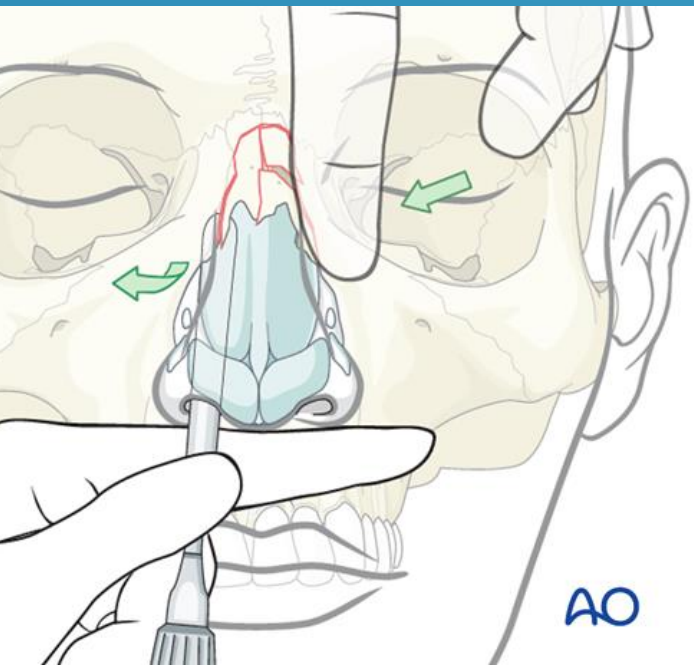
- ▶ Look to see if misaligned, point tenderness or crepitus. X-RAY NOT NEEDED
- ▶ Cosmetically is it a problem? Will glasses sit right?
- ▶ Breathing affected?
- ▶ Septal hematoma rare but should be evaluated and ruled out

ASSESSMENT



- ▶ EVALUATION ideally 2-3 days after onset of injury. ERR ON SIDE OF EARLIER
- ▶ Time is of the essence: after 2 weeks, bones are setting and much harder to reduce

CLOSED NASAL REDUCTION



- ▶ Crusting and soreness in nose
- ▶ Now, scabbing and pustules
- ▶ No major congestion, unless getting really crusty
- ▶ No drainage, sometimes red on outside

NASAL PROBLEM

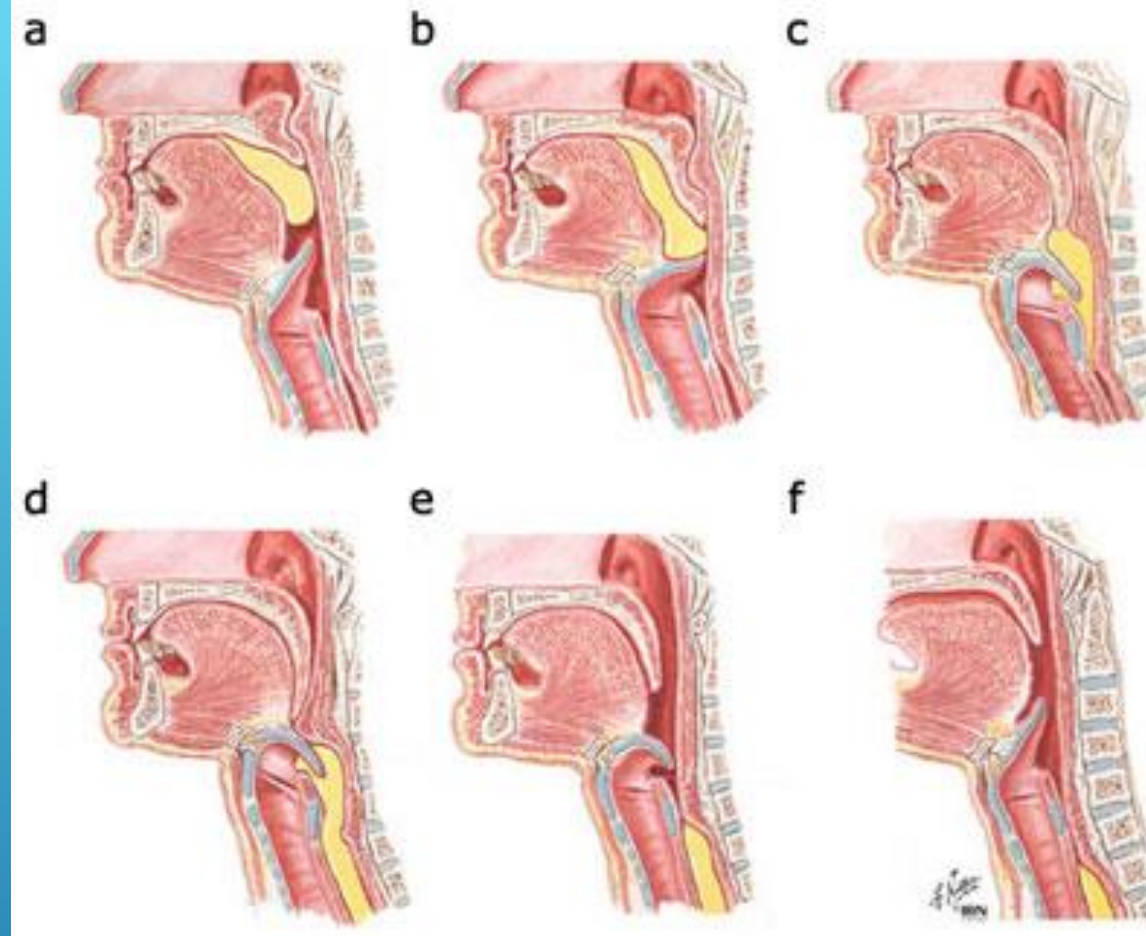


- ▶ Risk factors: nose plucking/waxing, nose picking, nose blowing, piercing
- ▶ 14 day trial of BID Mupirocin
- ▶ Rarely need oral antibiotic, but culture helpful/necessary only if not responding OR if having upcoming surgery (ESPECIALLY orthopedic, with hardware)
- ▶ Can become cellulitis or abscess

NASAL VESTIBULITIS



- ▶ Loud gurgling noises from the neck and chest
- ▶ Bloating and discomfort in the neck, chest, and abdomen
- ▶ Excessive flatulence



27 YO MAN C/O
“I CAN’T BURP”

- ▶ Botulinum toxin to weaken UES 88% at first visit
- ▶ Often with lasting results, can be repeated
- ▶ Risk of mild dysphagia (30%) usually transient

RETROGRADE CRICOPHARYNGEAL DYSFUNCTION

- The common ENT problems will be frequently seen and treated by PCP
- More difficult problems, or when recurrent, are appropriate for referral

IN SUMMARY

