

Monash Children's Hospital Referral Guidelines PAEDIATRIC EAR, NOSE AND THROAT

EXCLUSIONS

Services not offered by Monash Children's Hospital

- Patients over 18 years of age: [Click here](#) for adult Monash Health Ear, Nose and Throat/Head and Neck guidelines.
- VPI is managed by the cleft clinic, refer to speech pathology and cleft clinic
- Speech concerns with a normal hearing test.
- Dysphonia < 4yo with out symptoms of airway compromise i.e. recurrent croup, stridor.
- Speech/articulation concerns with a normal hearing test.
- Severe Microtia and External auditory canal atresia : refer to RCH Microtia/atresia clinic
- For milder cases of microtia i.e. cup ears, consider ear moulding as new born (provided by private providers) and refer to Monash ENT (routine) closer to the age of 5.
- External auditory canal ear wax build up with no documented hearing loss

Referrals requiring a speech pathology report for referral to be accepted:

- Dysphagia
- Aspiration
- Dysphonia > 4years with no airway concerns

Referrals requiring an audiogram report for referral to be accepted:

- Recurrent acute otitis media
- Chronic OME
- Hearing loss
- Discharging ears
- Failed new born hearing screen
- Any referrals that involve the ear or hearing

Head of unit:

Dr Adnan Safdar

Program Director:

A/Prof Alan Saunder

Last updated:

9/12/2020



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CONDITIONS

THROAT

- [Dysphagia](#)
- [Dysphonia](#)
- [Tonsillitis - recurrent](#)
- [Snoring and Obstructive Sleep Apnoea](#)

NOSE/SINUS

- [Rhinitis](#)
- [Epistaxis – recurrent](#)
- [Sinusitis](#)

EAR

- [Otitis Externa](#)
- [Failed newborn hearing screening](#)
- [Discharging Ear](#)
- [Recurrent acute otitis media](#)
- [Otitis media with effusion](#)
- [Tympanic membrane perforation](#)

OTHER

- [Neck Mass](#)

PRIORITY

All referrals received are triaged by **Monash Children's Hospital clinicians** to determine **urgency of referral**.

EMERGENCY

For emergency cases please do any of the following:

- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

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REFERRAL

How to refer to
Monash Children's
Hospital

Mandatory referral content

Demographic:

Full name
Date of birth
Next of kin
Postal address
Contact number(s)
Email address
Medicare number
Referring GP details
including **provider number**
Usual GP (if different)
Interpreter requirements

Clinical:

Reason for referral
Duration of symptoms
Management to date and response to
treatment
Past medical history
Current medications and medication
history if relevant
Functional status
Psychosocial history
Dietary status
Family history
Diagnostics as per referral guidelines



[Click here](#) to download the outpatient referral form

CONTACT US

Medical practitioners

To discuss complex & urgent referrals
contact: On-call registrar via 8572 3000

General enquiries

Phone: 8572 3004

Submit a referral

Fax referral form to Monash Children's
Hospital Specialist Consulting Services:

Fax: 8572 3007

Email: scmonashchildrens@monashhealth.org

OR

Refer via electronic referral using
HealthLink. Details available at
<https://monashchildrenshospital.org/for-health-professionals/gp-ereferrals/>

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THROAT

Dysphagia

Initial GP Work Up

Clinical history

- Refer to a speech pathologist for assessment: referral to ENT will not be accepted without a speech pathology assessment and report.
- Consider gastroenterology causes and / or referral to gastroenterology

Physical examination

- Examine the child's mouth - in particular, tonsil size; assess for other signs of upper airway obstruction ie, snoring and OSA
- Is the patient developmentally appropriate?
- Is the child aspirating?
- Has there been a history of chest infections?

Management Options for GP

- Refer to speech pathology for assessment and report



WHEN TO REFER?

Emergency

- choking on food causing acute airway obstruction and apnea

Urgent

- Aspiration history with pneumonia requiring antibiotics
- Proven aspiration on speech pathology assessment with no obvious explanation

Routine

- All others

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THROAT (cont'd)

Dysphonia



WHEN TO REFER?

Initial GP Work Up

Clinical history

- All children with dysphonia with no airway symptoms (ie stridor or recurrent croup) are recommended to see community speech pathologist with an expertise in voice therapy
 - Children less than 4 years old with a rough voice but no airway symptoms (stridor or recurrent croup) are rejected from the ENT service.
- Document symptom:
 - quality of voice : hoarse, rough
 - does the child loose their voice, how often?
 - does the child “over use” their voice
 - are there any concerning features such as stridor, work of breathing, limited exercise tolerance to suggest airway obstruction or recurrent croup
- Children who present with a rough, hoarse voice with episodes of loosing their voice (aphonia) but no features of airway obstruction, are often suffering vocal nodules. For most children, it resolves as they go through puberty.
- Some children will have a significant impact of their dysphonia. These children would benefit from “voice therapy” through a voice speech pathologist. This service is not provided by Monash Health and should be sought in the community

Physical examination

- Examine the child's mouth - in particular, tonsil size; assess for other signs of upper airway obstruction ie, snoring and OSA
- Is the patient developmentally appropriate
- Is the child aspirating? Has there been a history of chest infections?

Management Options for GP

- Refer to speech pathology in the community for voice therapy for children with a significant functional impact of their dysphonia
- Address exacerbating factors such nasal obstruction, reflux, voice “over use” (shouting)

Emergency

- Dysphonia associated with neck trauma; and dysphonia associated with moderate to severe stridor and work of breathing

Urgent

- If symptoms of airway obstruction are present : stridor and work of breathing;
- If admitted to hospital for croup

Routine

- All others

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THROAT (cont'd)

TONSILLITIS – RECURRENT

WHEN TO REFER?

Initial GP Work Up

Clinical history

- Chronic or recurrent tonsillar infection (exudate on tonsils) with fever or malaise and decreased oral intake and any of the following:
 - four or more episodes in the last 12 months
 - six or more episodes in the last 24 months
 - tonsillar concretions (stones) with halitosis
 - absent from school for four or more weeks in a year
- If the tonsillitis is associate with snoring and OSA features, please refer to the OSA prereferral guidelines
- In < 2yo children with monthly “tonsillitis” with high fevers, consider referral to rheumatology for assessment of recurrent fever syndromes (in addition to an ENT referral)
- Most children with recurrent tonsillitis will spontaneously resolve with time

Physical examination

•Throat pain and/or pain on swallowing plus the presence of:

- Fever
- Tonsillar exudate
- Cervical lymphadenopathy

•Group A beta-hemolytic streptococcal (GABHS) is likely if the following are present:

- Tender and enlarged tonsillar cervical lymph nodes
- Inflammation of the tonsils and the rest of the pharynx
- Generalised erythematous (scarlatiniform) rash

Investigations

•Consider throat swab

Management Options for GP

- Manage acute episodes with antibiotics (penicillin) or active observation if thought to be viral.
- Supportive management with regular analgesia.
- Oral Prednisolone 1mg/kg x 3 days may help pain and improve oral intake

Emergency

Complications of tonsillitis and/or airway obstruction must be referred to the Emergency Department and/or discussed with the ENT Registrar on call (via main switch board **03 8572 3000**)

- Severe OSA (snoring, gasping at night)
- Dehydration due to poor oral intake that isn't responsive to oral medications

Urgent

- Acute on chronic tonsillitis, less than 3 weeks between episodes
- More than 2 admissions to hospital in 12months for tonsillitis

Routine

- All others

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THROAT (cont'd)

SNORING AND OBSTRUCTIVE SLEEP APNOEA

WHEN TO REFER?

Initial GP Work Up

Clinical history

- Snoring present >50% of the time for at least 3 months (regular snoring)
- Witnessed choking/gagging/apneas in sleep
- Unrefreshing or restless sleep
- Symptoms of daytime tiredness: poor concentration, behaviour concerns
- Choking and gagging on foods regularly
- Deterioration of symptoms with URTI or hayfever

Physical examination

- Document size of tonsils (grade 1-4);
 - https://i1.wp.com/www.scielo.br/img/revistas/rboto/v71n1/en_a04fig01.gif
- Presence of mouth breathing and/or nasal discharge
- Presence of noisy upper airway breathing whilst awake
- Video of sleep: presence of snoring and or work of breathing
- Nasal obstruction

Management Options for GP

- All children with a history of regular snoring, should consider a trial of nasal steroid spray
 - https://www.rch.org.au/kidsinfo/fact_sheets/asthma-videos/#how-to-use-a-nasal-spray
 - If symptoms resolve with nasal steroid use, these should be continued for 6 months
- Consider oral antihistamine (prn oral syrup) if allergies are a factor
- Treat chronic rhinitis (thick nasal discharge) with a course of augmentin duo (22.5mg/kg BD x 10days)
 - If ongoing nasal discharge, saline spray daily may help
- Patient OSA questionnaire. Score > 5 is suggestive of OSA. Score each question using the following criteria; 0 = non of the time; 1= some of the time; 2= most of the time; 3= all of the time:
 - loud snoring
 - breath holding spells or pauses in breathing at night
 - choking or gasping sounds while asleep
 - mouth breathing because of a blocked nose
 - breathing problems during sleep that made you worried that they were not getting enough air
- Refer patients to Safer Care Victoria decision tools regarding tonsillectomy
 - <https://www.bettersafecare.vic.gov.au/clinical-guidance/paediatric/making-a-decision-about-tonsillectomy>
- 30% of children with snoring, will spontaneously resolve their symptoms within 9 months.

Emergency

- Acute or chronic OSA with significant parental concerns and acute deterioration.
- Severe snoring with gasping, may have awake symptoms of noisy breathing. This generally occurs in patients less than 2years with a preceding history of snoring, and an acute deterioration with an URTI; or in teenagers suffering from EBV tonsillitis.
- Call on call ENT registrar (via main switch board **03 8572 3000**) or present ED for observation, antibiotics and oral steroids.

Urgent

- Regular snoring, with gasping and choking witnessed by the parents on most nights despite nasal steroid spray use.
- Proven Obstructive Sleep Apnoea on a sleep study or oximetry test.
- Co-existing craniofacial abnormality
- Regular snoring with obvious obstructive features (apnoea/choking) associated with failure to thrive

Routine

- All other presentations
- **PLEASE NOTE** – referral is based on symptoms not size of tonsils and will be triaged as per urgency by the ENT Consultant

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NOSE/SINUS

RHINITIS

WHEN TO REFER?

Initial GP Work Up

- Differentiate between chronic infective rhinitis and allergic rhinitis
- Chronic infective rhinitis is associated with thick "green/yellow" nasal discharge, this is associated with viral or bacterial infection of a chronic or relapsing nature
- Allergic rhinitis is characterized by clear profuse nasal discharge, often associated with sneeze, itch and nasal obstruction
- This is associated with asthma, eczema and food allergies and there may be seasonal variation of symptoms
- Assess patient for nasal obstruction and snoring
- If snoring, please refer to OSA referral guideline
- Unilateral nasal discharge, if offensive in smell, is likely to be a nasal foreign body
- If associated with nasal obstruction and or nasal bleeding, this is concerning for a nasal mass

Emergency

Unilateral discharge with offensive smell must be referred immediately to the Emergency Department and/or discussed with the ENT Registrar on call (via main switch board 03 8572 3000)

Urgent

- Unilateral nasal discharge with nasal obstruction
- Rhinitis associated with severe OSA (see OSA referral guidelines)

Routine

All other conditions as specified

Management Options for GP

- Reassure parents
- Manage co-existing allergies
- Manage environmental factors
- Chronic infective rhinitis if > 4 weeks of thick green nasal discharge, consider a course of oral antibiotics (augmentin duo 22.5mg/kg BD x 10days)
- If ongoing despite antibiotics, trial nasal steroid spray (nasonex or avamys - 1 spray per nostril daily for 2 months)
- Saline spray prn may be beneficial to help clear the discharge
- Allergic rhinitis :
 - prn antihistamine to improve clear nasal discharge
 - nasal steroid sprays to treat nasal obstruction (nasonex or avamys - 1 spray per nostril daily for 2 months)
- Saline spray prn may be beneficial to help clear the discharge
- Consider blood tests : RAST (dust mites and grasses +/- cats or dogs), Total IgE; to help guide parents as to what allergens to avoid
- refer to allergy.org.au for further guidance

NOSE/SINUS (cont'd)

EPISTAXIS – RECURRENT

WHEN TO REFER?

Initial GP Work Up

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- Recurrent epistaxis in children is extremely common. Most cases are purely bothersome, and not reflective of a more serious problem.
- Flags for serious pathology :
 - associated unilateral nasal obstruction and or nasal discharge
 - associated iron deficient anaemia
 - bleeding /bruising from other sites

Clinical history

- Rule out allergic rhinitis
- If suspecting blood disorder:
 - Patient history (i.e. bruising, bleeding)
 - Family history

Physical examination

- Determine whether bleeding is
 - Unilateral or bilateral
 - Anterior or posterior
- Determine if coagulopathy, platelet disorder or hypertension is present

Investigations

- Blood tests – (FBE, PT, APTT) if indicated by history

Management Options for GP

- Reassure parents
- Prevention with nasal moisturizers
- Minimize itch associated with hayfever ie prn antihistmane
- Treat acute clusters of nose bleeds with BD antibiotic ointment for 1-2 weeks (chlorsig, nasalate, kenacomb). Directly apply ointment into nostril.
- Consider Nasal cautery if the above doesn't reduce the bleeds. This is not recommended for patients less than 6 years (behaviourally they do not tolerate it)
- If longstanding frequent epistaxis, check FBE and iron studies;
- If other sites of bleeding: consider work up for bleeding disorder : FBE, Coags, PFA 100; Von Willebrand screen.
- Further information:
- https://www.rch.org.au/kidsinfo/fact_sheets/Nosebleeds/#:~:text=Nosebleeds%20are%20very%20common%20in%20children.%20A%20nosebleed,they%20can%20burst%20easily%2C%20and%20start%20bleeding

Emergency

Intractable epistaxis despite appropriate first-aid measures for longer than 30 minutes must be referred to the Emergency Department and/or discussed with the ENT Registrar on call (via main switch board **03 8572 3000**)

Urgent

- Despite regular nasal ointments, recurrent epistaxis with Iron deficient anaemia
- Diagnosed Coagulation or platelet disorder with recurrent epistaxis
- Epistaxis with unilateral nasal obstruction

Routine

- All others

NOSE/SINUS (cont'd)

SINUSITIS (IN OLDER CHILDREN)

WHEN TO REFER?

Initial GP Work Up

Clinical history

- History and physical examination may be non-contributory
- Signs of sinusitis include:
 - Post nasal drip
 - Rhinorrhoea
 - Facial, periorbital, and frontal pain
 - Disturbance of smell and taste
 - Establish if chronic – persistent symptoms more than 8 weeks, recurrent or more than 3 episodes a year)

Physical examination

- Unilateral or bilateral nasal congestion, usually evolving from a viral upper respiratory tract infection

Investigations

- CT scan rarely indicated

Management Options for GP

- Reassure parents
- Manage co-existing allergies
- Manage environmental factors
- Treat any acute bacterial infection
- Saline rinse/irrigation (not spray)
- Allergy testing if indicated
- Topical steroid nasal sprays for perennial and seasonal allergic rhinitis, as well as perennial nonallergic rhinitis. (Long term use has not been shown to cause suppression of the hypothalamicpituitary – adrenal axis)
- In seasonal rhinitis – commence spray one month prior to the relevant pollen season and continue over the symptomatic period
- Antihistamines – do not use as a first line treatment but may be used for seasonal rhinitis.

Emergency

Complications of sinusitis such as severe pain, ocular problems, forehead swelling or drowsiness must be referred immediately to the Emergency Department and/or discussed with the ENT Registrar on call (via main switch board **03 8572 3000**)

Routine

- Persistent symptoms despite 6 weeks of appropriate treatment
- Where sinusitis is persistent and seems to exacerbate asthma symptoms
- Send any x-rays and/or CT if done
- Send pathology results if known, documentation of clinical course and treatment and response

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EARS

OTITIS EXTERNA

Initial GP Work Up

Clinical history

- Usually due to water contamination following swimming
- Children with dermatitis of the external ear canal

Physical examination

- Presents with inflammation of the ear canal and pre-auricular tenderness
- If copious mucus or pus consider perforated tympanic membrane
- Hearing loss

Investigations

- Swab ear discharge for microscopy/culture and sensitivity

Management Options for GP

- Reassure parents
- Education on protecting ears from water exposure
- Topical antibiotics
- Systemic antibiotics are rarely required
- If ear canal dermatitis is present (itch and flaky skin); consider prn elocon ointment to affected area
- Consider 'aqua ear' after swimming to prevent Otis externa

WHEN TO REFER?

Emergency

- Ear canal is swollen shut and antibiotic eardrops cannot enter the ear canal
- Cellulitis has extended beyond the ear canal in which case the child will need IV antibiotics

Routine

- Ear pain is severe and not relieved by regular simple analgesia
- Send pathology results if known, documentation of clinical course and treatment and response

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FAILED NEWBORN HEARING SCREENING

Initial GP Work Up

Clinical history

- All babies a screened for hearing loss at the time of birth. If the screening test produces a "fail" or the baby has risk factors, they are referred for a formal audiology testing.
- Babies who have severe hearing loss require further investigation ie MRI. MRI is best performed when they can naturally sleep through the scan (ideally < 3months). For this to be requested, early referral to a tertiary centre ENT or Hearing loss program is essential.

Management Options for GP

- Refer to ENT and PHILIC (2 separate referrals)
- If hearing loss > 40db, the patient may benefit from hearing aids. In children, all hearing aids are provided by Hearing Australia. Patients require a medical clearance form for hearing aids. This can be done by their GP.

WHEN TO REFER?

Urgent

- All patients with severe >60db hearing loss (uni or bilateral) on a formal audiogram, refer to PHILIC and Paediatric ENT to enable early MRI

Routine

- All patients with mild or moderate hearing loss ie < 60db

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EARS (cont'd)

DISCHARGING EAR

WHEN TO REFER?

Initial GP Work Up

Clinical history

- Children often suffer discharging ears associated with recurrent acute otitis media and tympanic membrane perforation; or discharging grommets

Physical Examination

- Bleeding from the ear canal often represents an ear infection.
- Swelling of the ear canal and / or spreading cellulitis indicates otitis externa or mastoiditis

Investigations

- Swab the ear canal and send for M/C/S
- Once discharge settles, organise an Audiogram

Management Options for GP

- Reassure parents
- If the child, has a generalised URTI (associated nasal discharge, generally unwell) or the discharge is profuse, oral antibiotics are recommended (amoxil or augmentin duo);
- If the discharge is offensive in smell, that is suggestive of pseudomonas. Topical antibiotic ear drops are required - ciprofloxacin 3 drops TDS for 3-5 days. (PBS authority number required : < 18yo and tympanic membrane perforation)
- The parent can clean the external ear with a clean towel or cotton tip. Hydrogen peroxide 3% drops can be used to help clean the discharge (few drops into the EAC, beware the Hydrogen peroxide bubbles).
- If the child has suffered several weeks of discharge, and the ear is painful, there could be a fungal infection. This can be treated with locacortin-vioform drops or fill the ear canal with kenacomb ointment (using a syringe by the GP). Sofradex drops can be used if the tympanic membrane is intact.

Emergency

- Spreading cellulitis despite treatment with oral antibiotics and ear drops
- Symptoms suggestive of meningitis (fever, photophobia, neck stiffness, behaviour change)
- Post auricular cellulitis and swelling suggestive of mastoiditis
- Associated cranial nerve palsy (facial nerve)
- Call on call ENT registrar (via main switch board **03 8572 3000**) or present ED for observation, antibiotics and oral steroids.

Urgent

- Continuous discharge that doesn't settle with 2 weeks of treatment (oral antibiotics and drops)
- Recurrent episodes of discharge with less than 4 weeks interval between episodes
- If a polyp is present in the ear canal

Routine

- All other patients with intermittent episodes of ear discharge that resolves with treatment
- Not accepted
- Asymptomatic patients with wax build up

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EARS (cont'd)

RECURRENT ACUTE OTITIS MEDIA

Initial GP Work Up

Clinical history

- Recurrent ear infections associated with URTIs, otalgia, recurrent ear discharge
- MUST have recent audiogram (within preceding 6 months)

Physical examination

- Middle ear effusion – loss of normal tympanic membrane translucency
- Yellowish discolouration or bulging of tympanic membrane

Investigations

- Ear discharge if present – swab for culture/sensitivity if indicated

Management Options for GP

- Reassure parents
- Adequate analgesia
- Treat acute episodes:
 - Amoxicillin (22.5mg/kg) BD for 10 days OR Augmentin duo (22.5mg/kg) BD for 10 days
 - Ciprofloxacin HC drops TDS for 3-7 days if otorrhoea
- Manage environmental factors:
- Consider adjusting day care attendance (or to smaller day care facility)
- Discuss with parents risk of passive smoke and AOM (RR-1.66)
- Encourage weaning of pacifier after 11 months (RR-1.24)
- Consider prophylactic antibiotics if less than 4 weeks between episodes
- Amoxicillin 20mg/kg once per day x 3 months

WHEN TO REFER?

Emergency

- Mastoiditis with facial nerve palsy, dizziness, meningitis must be referred immediately to the Emergency Department and/or discussed with the ENT Registrar on call (via main switch board **03 8572 3000**)
- Send pathology results if known

Urgent

- Prolonged single episode of AOM despite appropriate oral antibiotics for at least 2 weeks
- 6 episodes requiring antibiotics in 6 months

Routine

- If medical treatment has been unsuccessful and the child remains symptomatically unwell
- More than 3 episodes of acute otitis media in 6 months or more than 4 episodes in a 12 month period
- Send pathology results if known, documentation of clinical course and treatment and response

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EARS (cont'd)

OTITIS MEDIA WITH EFFUSION

Initial GP Work Up

Clinical history

- Hearing loss, balance and coordination problems, speech and language delay

Physical examination

- Middle ear effusion – loss of normal tympanic membrane translucency

Investigations

- Audiogram - ideally 2 audiograms at least 8 weeks apart documenting hearing loss
- Treat associated rhinitis and or ear infections

Management Options for GP

- Reassure parents/patient
- Review at 3 months - for persistent middle ear effusion or hearing loss
- Treat associated rhinitis and or ear infections
- Audiogram - ideally 2 audiograms at least 8 weeks apart documenting hearing loss
- If hearing loss > 40db on 2 audiograms, consider referral to Australian hearing for hearing aids whilst waiting for ENT surgery

WHEN TO REFER?

Urgent

- >40db hearing loss on 2 separate audiograms
- >40db hearing loss and evidence of speech and language delay

Routine

- Send documentation of clinical course, treatment and response
- If hearing tests have been performed send with referral

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TYMPANIC MEMBRANE PERFORATION

Initial GP Work Up

Clinical history

- Causes of a perforated eardrum are usually from trauma or infection
- If possible, ensure any foreign body is removed from ear canal

Physical examination

- Hole in the tympanic membrane
- Chronic or recurrent ear discharge
- Hearing loss

Investigations

- Audiogram (if possible)

Management Options for GP

- Reassure parents
- Topical antibiotic eardrops for discharging ear (e.g. Ciprofloxacin)
- Advise to keep ear dry
- Audiogram

WHEN TO REFER?

Routine

- Ongoing discharge for greater than three weeks
- Failure of dry perforation to heal after six months
- All non-acute long term perforated ear drums should be referred
- Send pathology results if known, documentation of clinical course and treatment and response
- **PLEASE NOTE** - a simple perforation of the ear drum as part of an acute otitis media and does not require a referral unless there are ongoing concerns after 6 months.

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OTHER

NECK MASS

WHEN TO REFER?

Initial GP Work Up

Clinical history

- history of tenderness with associated dysphagia, dysphonia, draining sinus, fever, or increasing neck mass

Physical examination

- Observe for:
 - Fluctuance
 - Erythema
 - Airway distress

Investigations

- Ultrasound of neck with notation of thyroid gland
- Thyroid function test if needed
- Full blood evaluation

Management Options for GP

- Reassure parents
- Ultrasound of neck, may do serially to monitor size
- Antibiotics if infective nature

Emergency

The following symptoms must be referred immediately to the Emergency Department and/or discussed with the ENT Registrar on call on call (via main switch board **03 8572 3000**):

- Any signs of infection, including fever, redness, swelling or pain
- Any pain that is not controlled with the prescribed pain medicine
- A mass or lump in the centre of the neck
- Infective lymphadenitis not responding to oral antibiotics
- Signs suggestive of abscess formation
- Signs of airway compromise including new onset snoring/osa

Urgent

- Neck mass greater than 3cm
- Recurrent neck mass infection within a 12month period
- Symptoms concerning for malignancy
- Painless neck mass with skin colour change - suggestive of MAIC

Routine

- All others
- Send blood tests results if known, documentation of clinical course and treatment and response

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