GP Masterclass ENT Hillingdon

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Overview

- Hearing Loss
- Otitis Media
- Eustachian Tube Dysfunction?

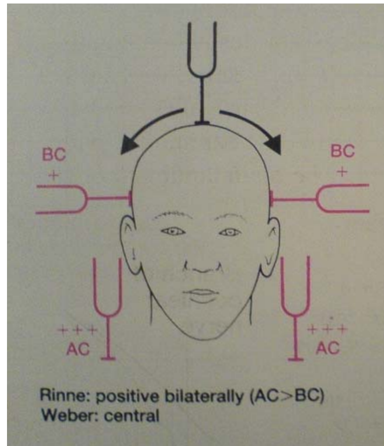
- Harpreet Nijar – Paediatric Audiology
- Jackie Dalton – Audiology Services

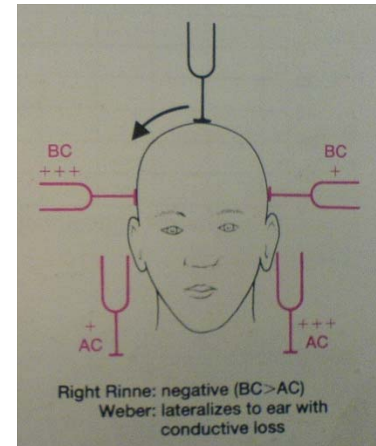
Tuning fork tests

Rinne's test - Test of middle ear function; Relies on AC>BC ; If AC>BC = Rinnes +ve

Webers test - Cochlear function; Conductive deafness – same ear, SNHL – opposite ear

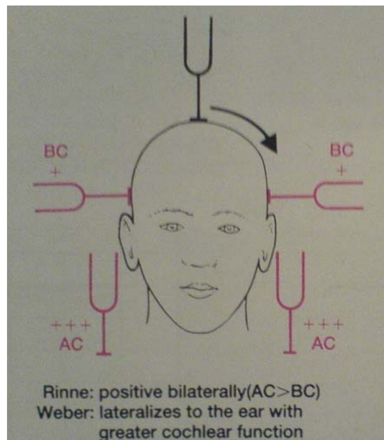
Normal hearing or bilateral SNHL

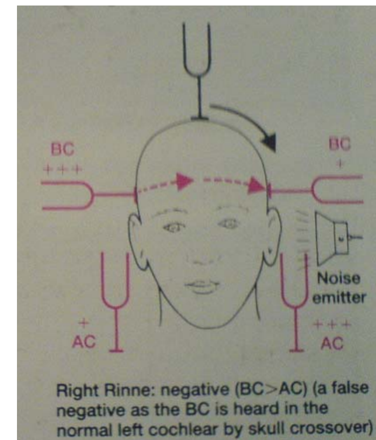




Right conductive hearing loss

Right sided SNHL





Right dead ear

Hearing Loss

- Conductive vs Sensorineural
- Gradual vs Sudden
- Bilateral vs Asymmetric/Unilateral

Hearing loss (adults)
Causes of hearing loss in adults

- **Conductive hearing loss**

o Middle ear infections (acute otitis media).
o Blockage of the outer ear, usually by wax.
o Otosclerosis
o Damage to the ossicles, for example by serious infection or head injury.
o Perforated (pierced) eardrum,
which can be caused by an untreated ear infection, head injury or a blow to the ear, or from poking something in your ear.

- **Sensorineural hearing loss**

o Age-related hearing loss (presbyacusis)
o Damage to the hair cells by loud noises - Noise-induced Hearing Loss
o Certain infections such as measles, mumps or meningitis.
Ménière's disease, which causes hearing loss, dizziness and tinnitus (a persistent ringing in the ears).
o Certain medicines, such as some powerful antibiotics, can cause permanent hearing loss. At high doses, aspirin is thought to cause temporary hearing loss and tinnitus.
o Certain cancer treatments, such as chemotherapy and radiation therapy, can cause hearing loss.
o Vestibular Schwannoma
o Cholesteatoma

- Mixed hearing loss is a combination of conductive and sensorineural hearing loss

Referral Threshold
Hearing loss (adults)

Suspected foreign body

Persistent hearing loss due to wax not relieved by ear drops or impacted wax

Referral for ear infections

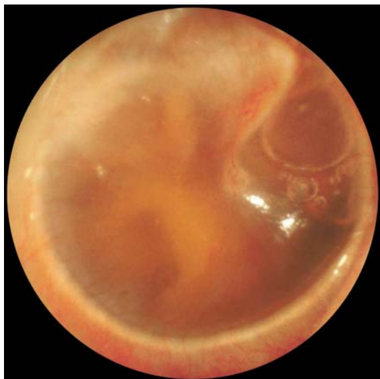
Unilateral sensori-neural hearing loss

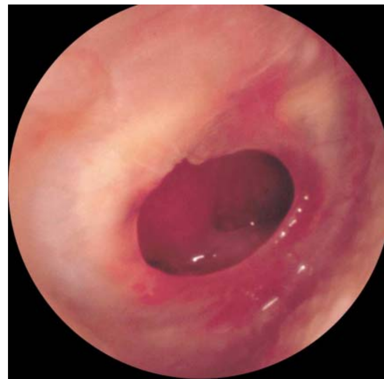
Referral for age related hearing loss (only if want a hearing aid)

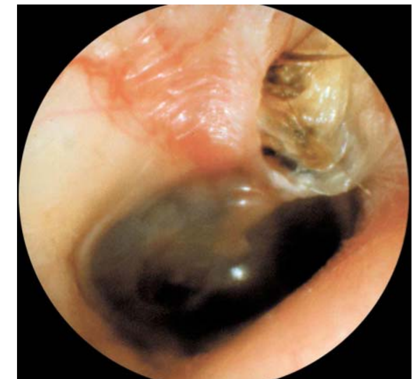
Sudden hearing loss

Chronic Otitis Media

• Squamosal	vs	mucosal
• Recurrent	vs	constant
• Attic	vs	tensa
• Central	vs	marginal
• Canal wall up	vs	canal wall down







Referral Threshold
Otitis Media

- Recurrent acute otitis media (either three or more acute infections of the middle ear cleft in a six-month period, or at least four episodes in a year)
- Unresponsive acute otitis media
- Suspected chronic suppurative otitis media
- Adult unilateral suspected secretory otitis media (for exclusion diagnosis of nasopharyngeal tumour)
- With persistent effusion should, be referred if:
    - features are atypical and accompanied by a persistent foul-smelling discharge suggestive of cholesteatoma (they are a greasy-looking mass or accumulation of debris that is seen in a retraction pocket or perforation in middle ear)
    - they have excessive hearing loss suggestive of additional sensori-neural deafness **(refer after audiology report)**
    - Children with **proven persistent hearing loss detected on two occasions separated by 3 months or more (results of formal testing should be included in the referral letter)**
    - Children with hearing problems plus difficulties with speech, language, cognition or behaviour
    - Children with hearing problems plus a second disability, such as Downs syndrome

Eustachian Tube Dysfunction - medical

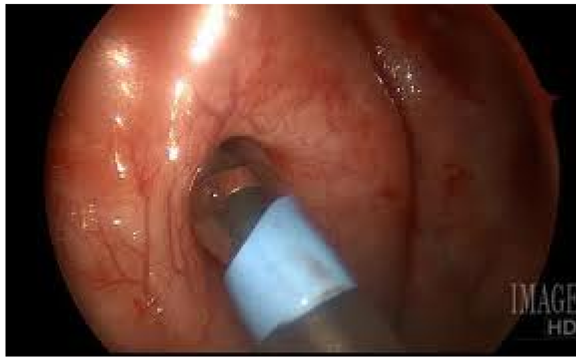
- Time
- Autoinsufflation (eg, an Otovent)
- Oral and nasal steroids (budesonide, mometasone, prednisone, methylprednisolone).
- Decongestants (eg, pseudoephedrine, oxymetazoline, phenylephrine)
  - Consider the cardiovascular effects of oral decongestants
  - limit the use of the decongestant to short-term symptomatic relief
- Nasal and oral antihistamines can also be beneficial in patients with allergic rhinitis.
- Leukotriene antagonists (eg, montelukast sodium [Singulair]) are helpful in some patients when oral steroids are not an option.
- Proton pump inhibitors (esomeprazole magnesium [Nexium], rabeprazole [Aciphex], omeprazole [Prilosec]) administered twice a day are often used
  - Adequate control of laryngeal pharyngeal reflux helps to resolve eustachian tube dysfunction (ETD) in patients with an associated peritubal inflammation from reflux.

Eustachian Tube Dysfunction - interventional

- The primary surgical treatment of all types of otitis media (OM) is myringotomy with tube placement.[
  - The typical ventilation tube stays in place for a period of 6-18 months
  - If poor eustachian tube function perforation may persist.

- Mastoidectomy, both canal wall up and canal wall down, can be used to treat complications of middle ear infection and eustachian tube dysfunction (ETD)

- Otovent / Earpopper



Balloon dilatation - What has NICE said?

Currently there is not enough evidence to be certain about how well this procedure works or how safe it is