

"Dedicated to the Health  
of the Whole Community"



**AMBULATORY & COMMUNITY  
HEALTH SERVICES**

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## Otolaryngology (ENT) Referral Guidelines

**Otolaryngology Clinic Location:** Valley Specialty Center 4th floor  
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**Otolaryngology Clinic Phone:** (408) 793-2540 (for patients)

**Otolaryngology Clinic Fax:** (408) 885-3016

This information is designed to aid practitioners in making decisions about appropriate medical care. These guidelines should not be construed as dictating an exclusive course of treatment. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institutional type of practice.

The California Department of Managed Health Care mandates that **URGENT** referrals are seen within 72 hours. To make this possible, these referrals require a provider to provider discussion so that the patient is scheduled in a timely manner. If you have a patient who needs to be seen on an urgent basis, please contact the on call doctor through the operator 408-885-5000 to expedite the patient's care.

If your patient has a medical emergency, please direct them to the closest emergency room for expedited care.

### **Please note:**

- The primary reason for referral rejection is absence of an audiogram.
- **Prior to referral for hearing loss, Chronic TM perforation, recurrent ear infection, and vertigo, patients need audiogram results.**
- Sudden hearing loss < 1 month should prompt a provider-to-provider communication for instructions.

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## ADULT OSA, SNORING

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### 1. Background

- a. Surgery is not a primary treatment for OSA and does not have a significant success rate in curing OSA – CPAP or tracheostomy are the gold standard treatments.
- b. When appropriate, surgery may be able to reduce CPAP settings/increase CPAP comfort and compliance

### 2. Pre-referral evaluation and treatment

- a. Testing
  - i. Polysomnography (PSG) via Pulmonary clinic
- b. Management
  - i. If patient is already being treated in pulmonary clinic with CPAP, can consider nasal medications to enhance CPAP delivery if mask use is uncomfortable.
    1. Flonase BID especially at night before bed.
    2. Conservative measures to keep nose moist – see epistaxis suggestions.

### 3. Indications for referral

- a. PSG and CPAP trial completed via pulmonary clinic AND evidence of anatomic obstruction (septal deviation or tonsillar hypertrophy) AND patient interested in surgery to REDUCE (not likely eliminate) CPAP use/CPAP settings. Pt may not be referred to ENT until PSG and CPAP trial are completed.

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## ADULT TONSILS

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### 1. Background

- a. Surgery can reduce pharyngitis episodes in patients with recurrent tonsillitis, and can reduce chronic throat symptoms in patients with chronic tonsillitis
- b. The presence of tonsilliths in the absence of recurrent acute or chronic tonsillitis is not an indication for surgery
- c. Tonsilliths are normal consequences of food and salivary residue getting stuck in tonsillar crypts, can be managed by gargling with water or dilute mouthwash after meals, cleaning stones out with a waterpik or soft infant toothbrush

### 2. Pre-referral evaluation and treatment

### 3. Indications for referral

- a. Greater than 6 episodes of tonsillitis in 1 year OR > 3 episodes per year for 3 years OR > 1 episode of peritonsillar abscess and patient interested (and qualified from a medical standpoint) in surgery
- b. Chronic daily throat pain with tonsillar enlargement and/or tonsilliths and/or halitosis and patient interested (and qualified from a medical standpoint) in surgery

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## ALLERGIC RHINITIS

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### 1. Background

- a. Most current referrals to ENT for this diagnosis are inappropriate (patients with allergy symptoms that have not had full trial of medical management or seen an allergist).

### 2. Pre-referral evaluation and treatment

- a. Management
  - i. Suspected allergic rhinitis should be treated with Flonase, nasal saline rinses, and an oral anti-histamine.
    - 1. If symptoms persist, patient should be referred to allergy clinic.

### 3. Indications for referral

- a. Persistent nasal obstruction after maximal medical therapy under allergist care with structural deficits (septal deviation and turbinate hypertrophy) that may be improved by ENT eval/surgery, with patient interested in/medically suitable for undergoing a surgical procedure to improve nasal breathing.
- b. If patient also meets criteria for ENT referral for chronic rhinosinusitis

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## ANOSMIA/HYPOSMIA

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### 1. Background

- a. Most commonly due to allergic rhinitis or post-viral. Less commonly caused by masses in the sinonasal cavity (polyps) or of the olfactory groove. Rarely related to neoplasm.

### 2. Pre-referral evaluation and treatment

- a. Primary care physician can prescribe trial of Flonase and/or Medrol dosepak or prednisone taper.

### 3. Indications for referral

- a. no improvement after medication trial as above
- b. PCP can see mass lesion in nasal cavity (nasal polyp or other, NOT turbinate hypertrophy)
- c. MRI orbit/face/neck with and without contrast may be performed prior to ENT visit to rule out olfactory groove mass

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## CERUMEN IMPACTION

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### 1. Background

- a. Patients commonly present for wax impaction or waxy ear drainage

### 2. Pre-referral evaluation and treatment

- a. Management
  - i. Counsel all patients with symptomatic cerumen to stop qtip use. OTC remedies can be suggested:
    1. Debrox 3-4 gtts to affected ear(s) 2-3x per week after shower/bath in patients without known history of TM perforation
    2. Mineral oil 3-4 gtts 2-3x per week after showers/baths in all patients
    3. Trial of removal by PCP or RN staff via irrigation

### 3. Indications for referral

- a. Above interventions for 1-2 months do not result in resolution of cerumen impaction
- b. Or, Patient has history of mastoid surgery
- c. Or, Patient has discharge evaluated by primary care physician that appears purulent or of other nature

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## CHRONIC DIZZINESS/VERTIGO

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### 1. Background

- a. Important for primary care physician to differentiate vertigo from lightheadedness – vertigo with a possible inner ear etiology has a sensation of seeing or feeling movement, usually rotatory. Light headedness – feeling faint, hot, visual changes, seeing dark spots or feeling like one will black out, feeling weak especially when standing up/getting down, is not typically inner ear in origin.

### 2. Pre-referral evaluation and treatment

- a. Testing
  - i. Audiology referral and audiogram before ENT visit

### **3. Indications for referral**

- a. Patient has true vertigo with hearing loss, tinnitus or other ear symptoms
- b. Audiogram needed before ENT evaluation
- c. Benign paroxysmal positional vertigo can be referred to neurology for eval/Epley maneuver

### **4. Please include the following with your referral**

- a. Results of audiogram

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## **CHRONIC NASAL OBSTRUCTION, NASAL CONGESTION**

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### **1. Background**

- a. Nasal obstruction may be related to structural issues with the nose (septal deviation, turbinate hypertrophy)
- b. However, they are almost always related to the condition of the nasal airway lining, which can be affected by irritants, allergies, chronic diseases.

### **2. Pre-referral evaluation and treatment**

- a. Management
  - i. Nasal hygiene should always be suggested first – nasal saline spray TID, sinus rinses at night, see suggestions under epistaxis.
  - ii. Flonase to both nostrils daily – BID should be trialed, daily use for at least 3 mos prior to referral.

### **3. Indications for referral**

- a. No improvement after medication trial as above
- b. Significant septal deviation or IT hypertrophy on exam AND patient interested in and medically appropriate for surgery
- c. Symptoms are only unilateral and progressive or associated with epistaxis, pain (concern for tumor)

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## **CHRONIC RHINOSINUSITIS (CRS)**

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### **1. Background**

- a. Signs and symptoms of CRS: need at least 2 of the sx below for > 12 weeks
  - i. Nasal obstruction
  - ii. Nasal congestion, pressure, fullness
  - iii. Discolored nasal discharge
  - iv. Hyposmia

- b. Only 65-80% of patients that meet the above criteria will actually have CRS when confirmed with CT scan evaluation
- c. Fewer than 5% of “sinus headaches” are found to be sinus in origin based on large studies.
  - i. If patient has primary complaint of chronic headache especially in the absence of above CRS symptoms, needs CT or MRI prior to evaluation in clinic (unless pediatric patient). Neurology department now requires that referrals for headache evaluation come from PCP with initial work-up and trial of medications.

## 2. Pre-referral evaluation and treatment

- a. Testing
  - i. Imaging strongly preferred (CT SINUS, no CT head) for any patient age 50 or older with symptoms of CRS.
    - 1. If other previously performed imaging (CT head with demonstrated sinus inflammation), okay to refer without repeat imaging.
- b. Management
  - i. Patients with CRS need daily nose/sinus treatment in addition to temporary regimen for sinusitis:
    - 1. Daily: flonase, nasal saline rinses (neilmed), allergy rx if indicated
    - 2. Temporary: augmentin x 2 weeks, consider prednisone taper (40x4, 20x4, 10x4 days)

## 3. Indications for referral

- a. Failure to resolve symptoms with the above treatment
- b. Multiple episodes (>3 in 6 mos or >4 in one year) that require the above treatment regimen
- c. Urgent referral
  - i. **Diffuse or focal** unilateral opacification noted on CT or MRI

## 4. Please include the following with your referral

- a. Results of imaging studies, summary of prior treatment

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## DRAINING EAR: OE or PERFORATED OM

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### 1. Background

- a. Otitis externa (infection of the ear canal, lateral to the TM) will present with ear pain, pain with movement of the pinna, purulent drainage from the ear
- b. A patient who first has an otitis media (middle ear infection behind the drum that may have had ear pain, fever, hearing loss) may then

perforate the ear drum with resulting drainage in the ear canal (infection is from middle ear, not from ear canal)

## **2. Pre-referral evaluation and treatment**

### **a. Management**

- i. Uncomplicated otitis externa or perforated otitis media should be treated with topical gtts – ofloxacin 5 gtts bid for 5-7 days.
- ii. Primary care physicians should also recommend dry ear precautions for any patient with a draining ear: cotton ball rolled in Vaseline to cover conchal bowl for showers, no swimming.

## **3. Indications for referral**

### **a. Urgent referral**

- i. Diabetic patient without resolution of OM or OE after 5-7 days of treatment
- ii. New facial nerve weakness or other cranial nerve abnormality associated with ear complaints, complicated otitis media (OM sx PLUS mastoid edema, erythema, tenderness, proptosis of ear, meningeal signs, temporal or facial swelling) , complicated otitis externa with fever, facial cellulitis.

### **b. Routine referral**

- i. No resolution after 5-7 days of topical treatment
- ii. EAC too swollen for gtts to get into canal (consider starting po antibiotic – ciprofloxacin 500 mg po bid - while patient awaits ENT appt for exam and wick placement)
- iii. Abnormal TM 6 weeks after resolution of ear discharge
- iv. Continued abnormal hearing 6 weeks after resolution of ear discharge
  1. Will need audio prior to ENT visit

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## **DRY/CHRONIC TM PERFORATION & ASSOCIATED HEARING LOSS**

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### **1. Background**

- a. Surgery for TM perforations is indicated to help with: chronic draining ear, or conductive hearing loss. If the pt is asymptomatic from their TM perforation, they do not need a referral to consider surgery.
- b. TM repair is ELECTIVE – generally, patients over 65, with poorly controlled DM or other significant medical conditions are not candidates for surgery

- c. Dry ear precautions (cover ear with cotton ball covered in Vaseline during all showers, avoid swimming) can resolve many cases of chronic ear drainage
- d. Patients who are not interested or not candidates for surgery can use a HA

## **2. Pre-referral evaluation and treatment**

- a. Testing
  - i. Referral to Audiology for audiogram

## **3. Indications for referral**

- a. May be non-urgently referred with audiogram required prior to ENT visit.

## **4. Please include the following with your referral**

- a. Results of audiogram

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# **DYSPHAGIA**

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## **1. Background**

- a. ENT can rule out causes of dysphagia visible above and to the level of the vocal cords. If pt describes food getting stuck and points to their chest, GI is a more appropriate referral.

## **2. Pre-referral evaluation and treatment**

- a. Testing
  - i. Esophagogram if isolated dysphagia
  - ii. CT scan neck with contrast if concern for tumor
- b. Management
  - i. Isolated dysphagia can be treated with PPI trial

## **3. Indications for referral**

- a. Urgent referral
  - i. If associated with Head and Neck cancer warning signs (eg neck mass, bleeding, wt loss, otalgia, voice change), patient should have CT scan neck with contrast ordered
  - ii. Dysphagia with hematemesis, melena, weight loss, or other warning signs for a GI process should have simultaneous urgent referral to GI team.
- b. Routine referral
  - i. Isolated dysphagia after PPI trial, should have esophagogram prior to ENT eval.

## **4. Please include the following with your referral**

- a. Results of imaging studies

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## EPISTAXIS

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### 1. Background

- a. Anterior epistaxis is common in both children and older adults, and most cases can be managed by preventing nasal dryness
- b. Unless active bleeding is not stopping or is accompanied by concerning symptoms such as nasal mass and obstruction, epistaxis is not a reason for urgent referral to ENT clinic

### 2. Pre-referral evaluation and treatment

- a. Management
  - i. Educate patients on how to stop a nosebleed:
    1. Do not stuff anything in the nose
    2. Sit up straight and tilt head slightly forward
    3. Use thumb and pointer finger to firmly pinch the soft part of the nose (squeeze nostrils together) – not over the nasal bones
    4. Hold pinch for 5-10 minutes without letting go
    5. Afrin over the counter spray to bleeding side can help, spray in bleeding side and may repeat again in 10 min if still bleeding
  - ii. Educate patients on how to prevent nosebleeds:
    1. Do not use ASA and NSAIDS if at all possible
    2. Hold flonase x 1 week
    3. Saline nasal spray or rinses 2-3x per day
    4. Use a humidifier in room at night, do not sleep w open windows/doors to the outside
    5. Vaseline to cover inside of both nostrils 1-2x per day, especially important at night before bed
    6. Control HTN or other controllable factors

### 3. Indications for referral

- a. Persistent after the above, especially if unilateral or severe
- b. Intermittent unilateral epistaxis associated with nasal congestion on the same side (concern for tumor)

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## GERD

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### 1. Background

- a. GERD complaints: feels like there is a ball or something stuck in my throat, feels hard to get food down my throat (but no actual difficulty passing food, no weight loss), thick mucous requiring throat

clearing especially in the morning, irritation felt when swallowing, sometimes with or without epigastric pain, voice feels wet or weak especially in the morning, often associated with OSA or obesity.

- b. Role of ENT consult is to ensure no additional pathology causing the symptoms (no laryngeal lesions, especially in those with tobacco or EtOH use).

## **2. Pre-referral evaluation and treatment**

### **a. Management**

- i. All patients should complete 3 mos trial of daily PPI AND lifestyle recommendations for GERD (avoid EtOH, tobacco, caffeine, chocolate, spicy foods, onions, eating within 2h of bedtime, elevate HOB while sleeping) prior to ENT eval unless they have other worrisome sx for laryngeal pathology or significant HN cancer risk factors or concerning symptoms for tumor, eg wt loss, otalgia, neck mass, bleeding, SOB

## **3. Indications for referral**

- a. Not improved on 3 mos PPI trial
- b. Associated risk factors or sx concerning for Head and Neck cancer
- c. Urgent referral to ENT and GI for sig weight loss, hemoptysis, hematemesis, melena, otalgia, neck mass

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## **HEAD AND NECK CANCER**

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### **1. Background**

- a. Risk factors: EtOH, tobacco, 40s-60s, male. South Asians at risk for NPC. Salivary gland cancers are not EtOH/tobacco related.
- b. Signs: hoarseness or hemoptysis, otalgia, neck mass, odynophagia, weight loss, unilateral epistaxis or hearing loss.

### **2. Pre-referral evaluation and treatment**

### **3. Indications for referral**

- a. If any of the above signs + risk factors. If the patient meets these criteria, consider contacting ENT ON CALL to expedite clinic evaluation, and advice on any needed imaging.

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## **HEARING LOSS, CHRONIC > 3 mos**

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### **1. Background**

- a. Hearing loss for > 3 mos duration WITHOUT ear pain, ear drainage, TM perforation, or prior history of ear surgery (tympanoplasty or mastoidectomy).
- b. Most likely presbycusis, noise induced hearing loss, sometimes chronic non suppurative ear disease.

## **2. Pre-referral evaluation and treatment**

- a. Testing
  - i. Audiology evaluation
    - 1. Must be completed BEFORE ENT evaluation is scheduled. Patients will not be seen in ENT clinic for this diagnosis without an audiogram.
    - 2. Patients with qualifying coverage can be referred to VMC audiology; patients without qualifying coverage (Medi-Cal, MCMC, APD) can be referred to outside centers for out of pocket audiograms. If the patient is not willing to pay out of pocket for an audiogram, they cannot be evaluated in ENT clinic for chronic hearing loss.

## **3. Indications for referral**

- a. Refer for:
  - i. Ear pain
  - ii. Ear drainage
  - iii. TM perforation
  - iv. Prior history of ear surgery (tympanoplasty or mastoidectomy)
  - v. Chronic hearing loss - non-urgent
    - 1. Goals
      - a. Rule out a correctable cause of hearing loss (infection, structural problem)
      - b. Offer hearing aids if patient qualifies
        - i. If patient would not be interested in hearing aids, they may want to consider whether or not they want a referral to ENT (esp if they need a pay out of pocket audiogram).
- b. Repatriation
  - i. Once the patient's hearing loss has been evaluated and/or hearing aids obtained, no further follow-up is needed with ENT.

## **4. Please include the following with your referral**

- a. Results of audiogram

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## HOARSENESS

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### 1. Background

- a. Persistent significant audible change in voice strength and quality – NOT a slight intermittent variable change.

### 2. Pre-referral evaluation and treatment

### 3. Indications for referral

- a. Persistent for 2-4 weeks in the absence of URI
- b. Referral is especially indicated if associated with hemoptysis, odynophagia, otalgia, neck mass or in a patient with a history of EtOH/tobacco use. Please specify the presence of these associated symptoms, as more urgent visit may be warranted.

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## NASAL FRACTURE, NASAL TRAUMA

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### 1. Background

- a. The goal of immediate evaluation (<10 days from injury) of nasal fracture is to determine whether or not the patient would benefit from a closed nasal reduction to improve nasal breathing and/or decrease acquired deformity.

### 2. Pre-referral evaluation and treatment

### 3. Indications for referral

- a. Emergent referral
  - i. Nasal fractures with septal hematoma are emergent consults that should be triaged through the ENT on call.
- b. Urgent referral
  - i. Nasal cellulitis needs to be seen at ER/urgent care or triaged through ENT on call if not responsive to anti-MRSA medications within 24 hours of onset.
- c. **URGENT** referral
  - i. Nasal fractures with visible external cosmetic deformity need evaluation by ENT ideally within 5 days from injury. Please specify date of injury to help us triage the referral.
- d. Do not refer
  - i. No ENT evaluation is indicated if patient does not feel any difficulty breathing and/or does not appreciate any cosmetic difference in the appearance of the nose.
  - ii. If patient is >14 days from injury, or is not a candidate (due to medical conditions) or not interested in surgical intervention, no referral is needed.
    - 1. Alternatively, in these latter cases referral can be made on a non-urgent basis to discuss medical

management of nasal congestion or outside options for correction of cosmetic deformity.

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## (ADULT) NECK MASS

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### 1. Background

- a. Benign conditions that commonly present with neck mass: congenital cysts (thyroglossal duct or branchial cleft), benign masses of the salivary glands, lymphadenitis
- b. In children, enlarged lymph nodes related to a URI or other infection can persist for up to 6 mos – 1 year, we do not usually consider excision until significantly after this point and only after medical workup exhausted
- c. Acute lymphadenitis with possible abscess (fever, tenderness, significant edema, fluctuance, not responsive to po antibiotic trial) needs to be evaluated urgently but may be best evaluated in pedi urgent care or the ER as the next step would be to consider IV antibiotics and imaging. Feel free to call ENT for advice
- d. Malignant conditions that can present as neck masses: HN cancer, salivary gland cancer, thyroid cancer, lymphoma.

### 2. Pre-referral evaluation and treatment

- a. Testing
  - i. CT neck with contrast should be done prior to ENT eval
    1. If thyroid mass, then thyroid US should be done.
    2. If thyroid US indicates concerning nodule, pt should be referred to IR for fna of concerning nodule prior to ENT

### 3. Indications for referral

- a. Lymphadenopathy persistent for > 6 weeks in a patient > 35yo
- b. Neck mass of any other nature concerning for neoplastic process
- c. Thyroid nodules may be referred when concerning findings on fna (indeterminate, suspicious or cancer), or even when benign if nodule is >3cm, or if nodule or overall goiter size is causing dysphagia, pressure, obstructive sx, or if nodule or goiter is enlarging over time.

### 4. Please include the following with your referral

- a. Results of imaging studies

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## SALIVARY GLAND MASS, INFECTION

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## 1. Background

- a. Masses of the submandibular gland can be confused with enlarged lymph nodes in the area

## 2. Pre-referral evaluation and treatment

- a. Testing
  - i. CT with contrast if mass palpated in parotid or submandibular gland
- b. Management
  - i. Sialadenitis can often be treated conservatively: sialogogues (lemon drops), warm compresses, increase hydration, decrease diuretics.
    1. If not responsive to the above and evidence of cellulitis or systemic signs/symptoms of infection, treat with PO antibiotics (clindamycin 450mg po tid for 7-10 days).

## 3. Indications for referral

- a. Mass palpated in the parotid or submandibular gland. Should have CT with contrast ordered first.
- b. Chronic infection or evidence of stone on CT scan or infection not resolving with PO antibiotic therapy.
  - i. Surgery only indicated for acute abscess drainage (rare), if chronic/recurring symptoms are enough for patient to desire a surgery for this overall benign process as over time most recurrent infections even those with obstructive stones will burn out.

## 4. Please include the following with your referral

- a. Results of imaging studies

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## SUDDEN SENSORINEURAL HEARING LOSS, < 4 weeks

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### 1. Background

- a. Hearing loss of less than 4 weeks duration. Usually unilateral and accompanied by acute onset of tinnitus in that ear.
- b. About 50% of these patients recover some hearing, whether they are treated or not.

### 2. Pre-referral evaluation and treatment

- a. Testing
  - i. Audiogram is important as the severity/pattern of hearing loss has prognostic value and is important to establish a baseline, preferably before initiating steroid therapy.

- b. Management
  - i. True SSNHL is treated with oral steroid taper.

### **3. Indications for referral**

- a. REFERRAL SUGGESTED FOR ALL HEARING LOSS OF LESS THAN 4 WEEKS DURATION
- b. Also refer urgently for audiology evaluation.
- c. Contact ENT on call to expedite evaluation
  - i. If no VMC audio qualification and if no contraindications (poorly controlled DM, significant psych disease, PUD, glaucoma) we may treat them with oral steroids while we await audio result
  - ii. If no response or if contraindication to systemic therapy some patients may be treated with intratympanic steroid injections.

### **4. Please include the following with your referral**

- a. Results of audiogram

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## **SUDDEN HEARING LOSS, 4 weeks – 3 mos**

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### **1. Background**

- a. Sudden sensorineural hearing loss outside of the 4 week window is much less likely to respond to any kind of therapy.

### **2. Pre-referral evaluation and treatment**

- a. Testing
  - i. Audiology referral and audiogram before ENT visit

### **3. Indications for referral**

- a. Referral serves to evaluate hearing loss via audiogram, discuss pathophysiology with patient, and offer hearing aids if qualified.
- b. Oral steroid therapy would still be offered in some cases, unlikely that intratympanic therapy would be offered.
- c. Non urgent referral to ENT is appropriate for these patients.

### **4. Please include the following with your referral**

- a. Results of audiogram

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## **TINNITUS**

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### **1. Background**

- a. Ringing, whooshing or pulsing sounds in one or both ears. Most cases of tinnitus are associated with some mild, chronic hearing loss.
  - i. If hearing loss is significant enough, wearing a hearing aid can help with the tinnitus.
- b. Some cases may be associated with mild Eustachian tube dysfunction, with or without hearing loss – occasionally this is treated with nasal sprays or with PETs if significant symptoms/conductive hearing loss.
- c. Rarely, pulsatile tinnitus is caused by a middle ear or neck tumor.

## **2. Pre-referral evaluation and treatment**

- a. Testing
  - i. Audiology referral and audiogram before ENT visit
- b. Management
  - i. There is no medical or surgical treatment for this type of tinnitus.
  - ii. Primary care providers can suggest masking strategies (white noise machines, music, fans at night), OTC supplements (no clinical evidence of benefit but not harmful so many patients want to try). The majority of patients complaining of tinnitus fall into this previous category.

## **3. Indications for referral**

- a. Tinnitus is unilateral and associated with sudden hearing loss or sudden true vertigo. See urgent referral for SSNHL<4 weeks above.
- b. Unilateral tinnitus with significant, asymmetric hearing loss on audiogram
- c. Constant, unilateral pulsatile tinnitus
- d. All tinnitus referrals must have an audio evaluation prior to ENT visit.
- e. Goal of ENT eval would be to offer HAs or medications in qualifying patients.

## **4. Please include the following with your referral**

- a. Results of audiogram

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## **TMJ**

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### **1. Background**

- a. Often confused with otalgia. If pt complains of ear pain and has no other associated ear sx (hearing loss, drainage, infection) and has a normal TM exam then TMJ should always be suspected.

- b. There will be tenderness to palpation anterior to the ear that is often worse with opening and closing the jaw. There may be clicking with opening or closing. Pain may be worse with chewing. There may be pain and tenderness in face/neck due to associated muscle spasm.

## **2. Pre-referral evaluation and treatment**

- a. Management
  - i. Conservative measures include NSAIDS, warm compresses, and soft diet when pain flares.
  - ii. Patients should be referred to dentistry for the consideration of a night splint.

## **3. Indications for referral**

- a. Consider ENT referral only if true ear pathology suspected as a cause for ear pain, or if etiology of sx/s/pain is uncertain
- b. Do not refer
  - i. ENT does not treat this condition; we do not do surgery for TMJ
  - ii. Recommend referral to pt's dentist for eval as above.

### Revisions:

- March 2017, formatting