Protocol for Audiology Referrals to ENT

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1. Background Information

1.1. Summary

It is standard practice in the UK for patients with suspected hearing loss to be directly referred to Audiology departments by their GP. NICE guidance exists to identify clear criteria for onward referral from Audiology to ENT (NICE, 2018). This protocol outlines how and under what conditions Salisbury Audiology Department will refer to ENT.

1.2. Documents and departments consulted

In the writing of this protocol discussions were undertaken with Salisbury ENT department. Documents consulted were:

- Hearing Loss in Adults: Assessment and Management (NICE, 2018)
- Guidance for Audiologists: Onward referral of Adults with Hearing Difficulty Directly Referred to Audiology Services (British Academy of Audiology Service Quality Committee, 2016).

2. Onward Referral to ENT – Criteria from Patient History

2.1. Sudden hearing loss or sudden deterioration of hearing

If hearing loss has occurred suddenly (within 72 hours) within 30 days of the appointment the Audiologist will alert ENT immediately; prompt treatment may increase the likelihood of recovery (BAA Service Quality Committee, 2016). If the hearing loss occurred suddenly over 30 days ago refer the patient to ENT urgently.

2.2. Tinnitus and Hyperacusis

Patients with tinnitus which is pulsatile, has significantly changed in nature or is causing distress should be referred to ENT as a routine patient. Patients with hyperacusis

causing distress should also be referred routinely onwards. Patients who display suicidal intentions should be discussed with their GP urgently. Unilateral persistent cases of tinnitus lasting for longer than 3 months should be referred for MRI Scanning – please see MRI scan policy.

2.3. Vertigo

Patients with recurrent vertigo or vertigo which has not fully resolved should be referred to ENT. Vertigo in this instance is defined as an illusion of movement (spinning, swaying etc). Patients with general unsteadiness should be referred back to their GP. Patients who give a history which clearly indicates Benign Paroxysmal Positional Vertigo (BPPV) can be discussed with a member of the vestibular team who can arrange for a repositioning manoeuvre to be conducted.

2.4. Otalgia

Patients with persistent and intrusive pain which has not resolved as a result of prescribed treatment should be referred on to ENT. Patients with intermittent or less severe pain should be directed back to their GP as should those who have not yet sought any treatment.

3. Onward Referral to ENT – Abnormal Otoscopy

3.1. Excessive ear wax

Patients with ear wax preventing further audiological management should be directed back to the GP or alternative provider for wax removal before contacting us for a further appointment.

3.2. Other abnormalities

Patients with any other aural abnormality (i.e. perforated tympanic membrane, active discharge) should be referred to ENT if they are not currently receiving any treatment for this. No referral is necessary for long-standing perforations which are dry and have previously been examined.

4. Onward Referral to ENT – Tympanometry

4.1. Unilateral flat tympanogram

Patients with a unilateral flat tympanogram should always be referred to ENT because of the risk of nasopharyngeal carcinoma (Sham et al, 1992). This is irrespective of audiometry results.

5. Onward Referral to ENT – Audiometry

Audiometry should be performed in accordance with the recommended British Society of Audiology (BSA) procedure (BSA, 2018).

5.1. Conductive hearing loss

For the purposes of this document a conductive hearing loss is defined as a 20dB or greater average air-bone gap over three of the following frequencies 500, 1000, 2000, 3000 or 4000Hz. Patients with a conductive hearing loss in the absence of middle ear effusion should be referred directly to ENT. Patients with suspected bilateral otitis media with effusion should not be directly referred to ENT. Initially they should be given advice regarding the Otovent nasal balloon (NICE, 2016) and then reviewed in three months. If their hearing loss and symptoms continue, then a referral should be made. As per section 4.1 patients with a unilateral flat tympanogram should be referred straight to ENT.

5.2. Asymmetrical or unilateral hearing loss

As per the protocol for direct audiology referral for MRI, patients who have a unilateral or asymmetric sensorineural hearing loss with an asymmetry of 15 dB or more at 2 adjacent test frequencies an octave apart will not routinely be referred to ENT (they will be sent for MRI instead). Patients for whom an MRI is contraindicated (see MRI protocol for details) will however be referred to ENT.

5.3. Deterioration of hearing

If there is marked deterioration of hearing thresholds by comparison to a prior audiogram in the last 24 months a referral to ENT should be considered. For the purposes of this document deterioration is defined as a sensorineural drop of 15dB or more at two or more frequencies.

5.4. Hearing loss which does not seem to be age-related

Consider referring adults with a sensorineural hearing loss which does not seem to be age-related to ENT. Noise exposure and patient history should be taken into account.

6. Seeking Advice

It may not always be clear which patients require onward referral. If there is doubt about a patient's suitability then Audiologists are expected to seek the advice of more senior colleagues before making a professional judgement.

7. Further Audiological Management

Referral onwards should not normally delay hearing aid provision except when the Audiologist does not feel it is safe to proceed (BAA, 2016). Thorough ear examination must be conducted prior to any impression taking (BAA, 2013).

8. References

British Academy of Audiology Service Quality Committee (2016) *Guidance for Audiologists: Onward referral of Adults with Hearing Difficulty Directly Referred to Audiology Services.*

British Society of Audiology (2013) *Recommended Procedure: Taking an aural impression.*

British Society of Audiology (2018) *Recommended Procedure: Pure-tone air-conduction and bone conduction threshold audiometry with and without masking.*

National Institute for Health and Care Excellence (2016) *Otovent nasal balloon for otitis media with effusion Medtech innovation briefing (MIB59)*

National Institute for Health and Care Excellence (2018) *Hearing Loss in Adults: Assessment and Management (NG98)*

Sham, S.H., Wei, W.I., Lau, S.K., Yau, C.C. and Choy, D. (1992) Serous otitis media. An opportunity for early recognition of nasopharyngeal carcinoma. *Archives of Otolaryngology Head and Neck Surgery.* Volume 118 (8), pp. 794-797.