

ENT In The Hospital Setting

TOM A. HAMILTON, D.O.

OTORHINOLARYNGOLOGIST

Goals of Lecture

- Most common ENT issues
- Evaluation process
- Strategy of management

OVERVIEW

- × Surgical Airway
- × Angioedema
- × Infection
- × Dysphonia
- × Fractures
- × Epistaxis

SURGICAL AIRWAY

- × Cricothyrotomy
- × Tracheotomy

Cricothyroidotomy

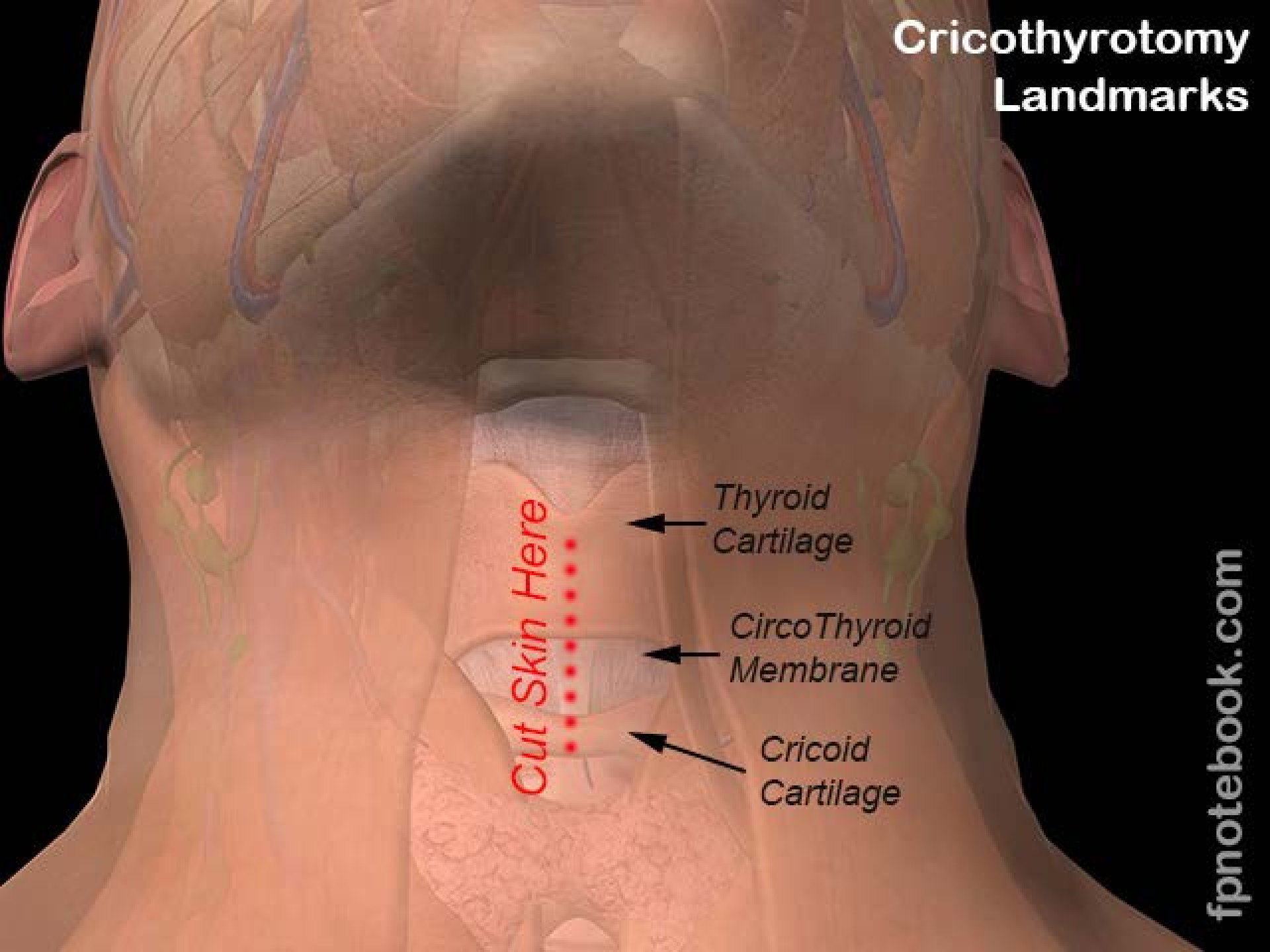
Almost without exception an emergency airway procedure only.

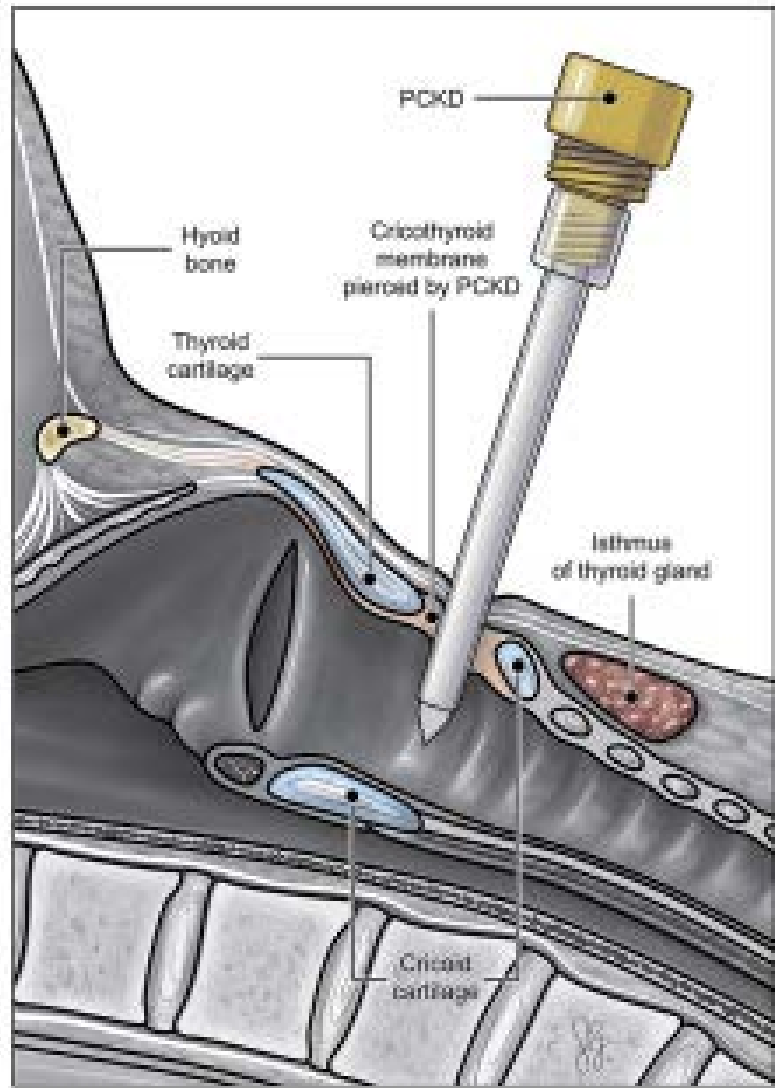
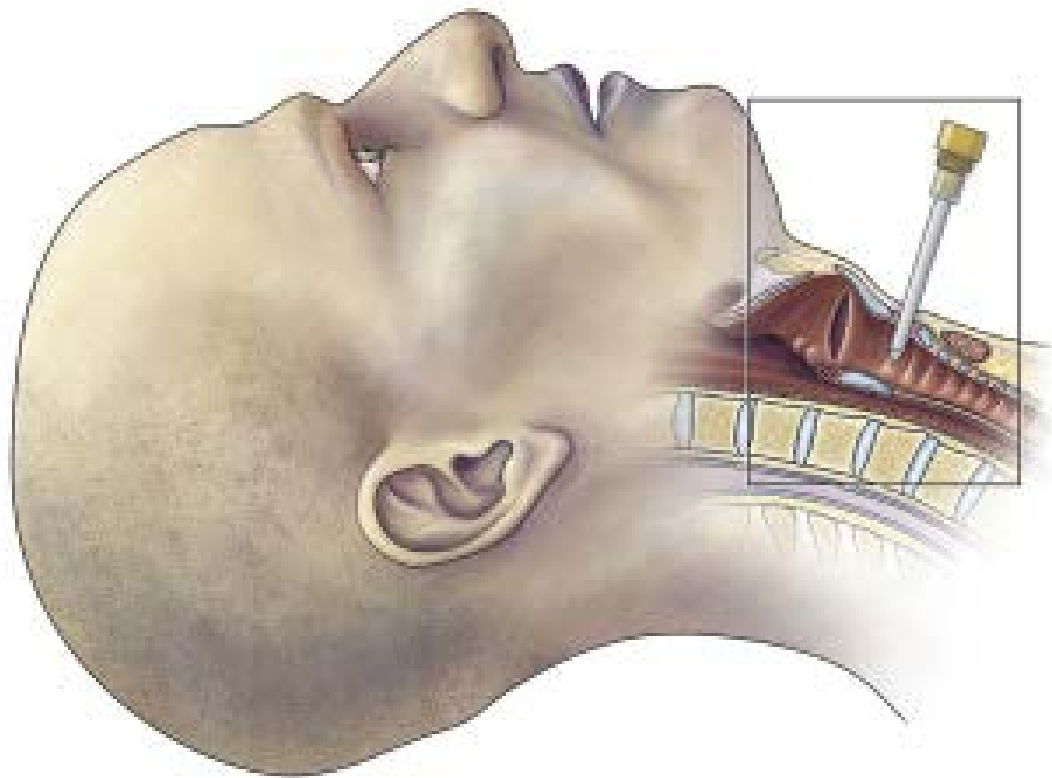
Should be able to perform at bedside.

CRICOTHYROTOMY

- × Verify Anatomy
- × Vertical incision through skin
- × Horizontal incision in cricothyroid membrane
- × Insert tube

Cricothyrotomy Landmarks





Tracheotomy

Indications:

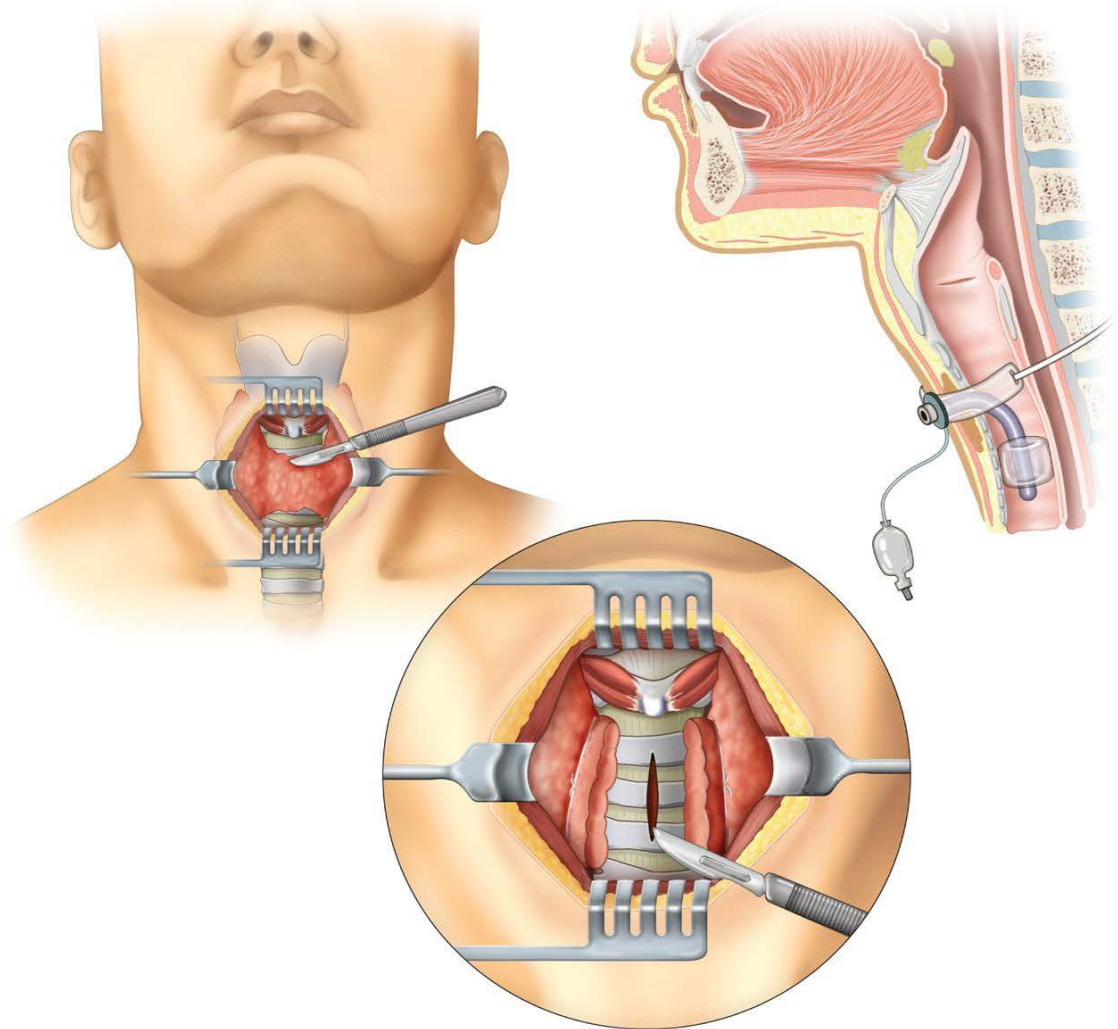
Prolonged intubation

Management of pulmonary secretions

Airway Malignancy

Severe obstructive sleep apnea

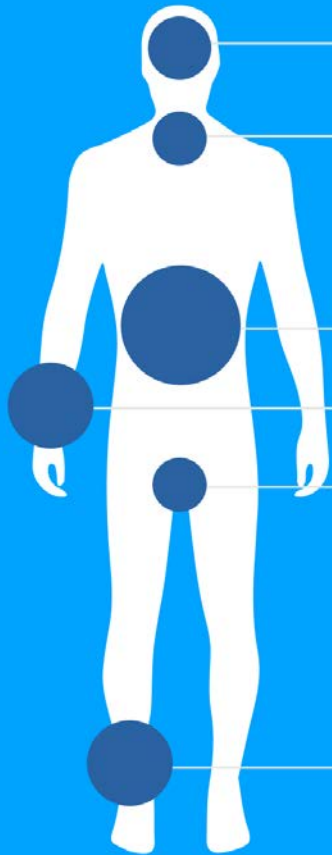
Tracheotomy



Angioedema

Hereditary or acquired
C1-esterase

Drug Induced
ACE inhibitors
ARB's
t-PA



Face

Throat

Abdomen

Hands

Genitals

Feet



a Apr. 15th 08:08 p.m.



b Apr. 15th 09:45 p.m.



c Apr. 15th 10:44 p.m.



d Apr. 16th 10:47 p.m.



e Apr. 16th 00:50 a.m.



f Apr. 16th 01:06 a.m.



Fig. 1



A**At 54 min****B****At 76 min****C****At 117 min****A****B**



25% obstruction of
supralarynx

Grade LOC I

Monitory

50% obstruction of
supralarynx

Grade LOC II

Monitory

75% obstruction of
supralarynx

Grade LOC III

Monitory and
tracheotomy stand by

90% obstruction of
supralarynx

Grade LOC IV

Save the air way
Intubation, coniotomy
or tracheotomy

Infections

1. Epiglottitis
2. Peritonsillar abscess
3. Parapharyngeal abscess
4. Ludwig's Angina (Cellulitis of Floor of Mouth)
5. Mastoiditis

Epiglottitis

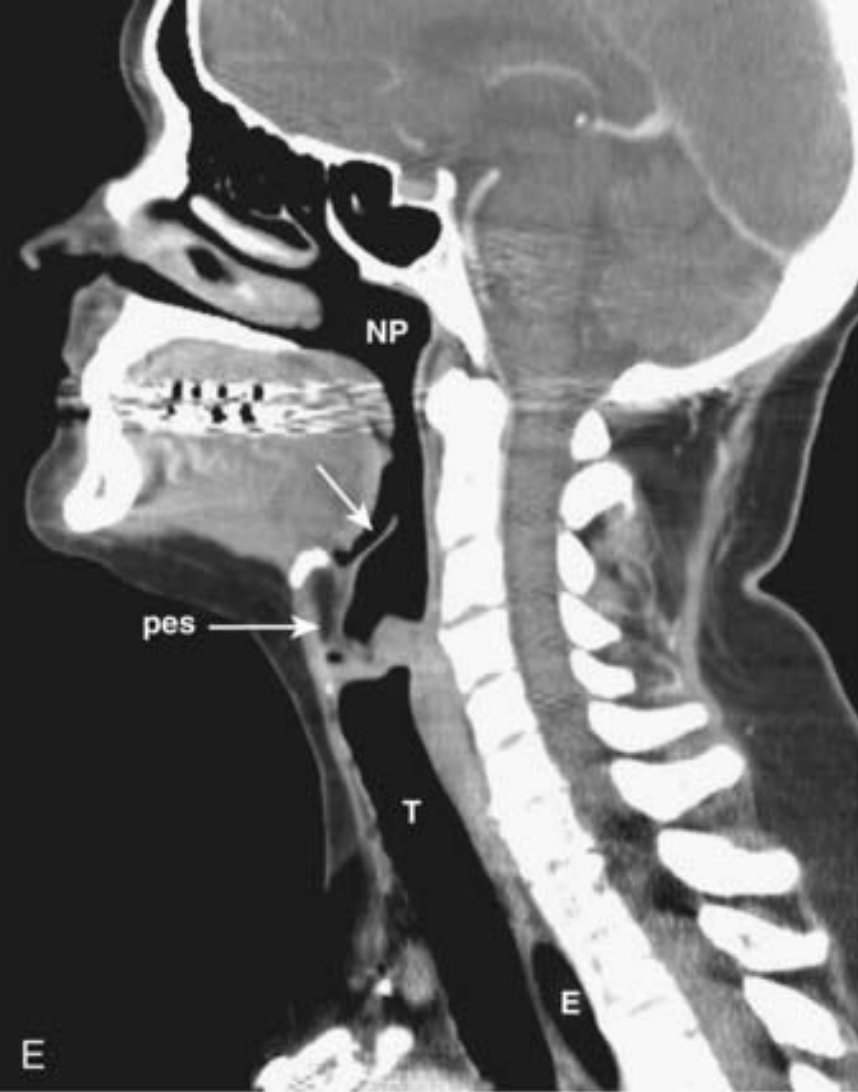
Preceded by upper respiratory infection

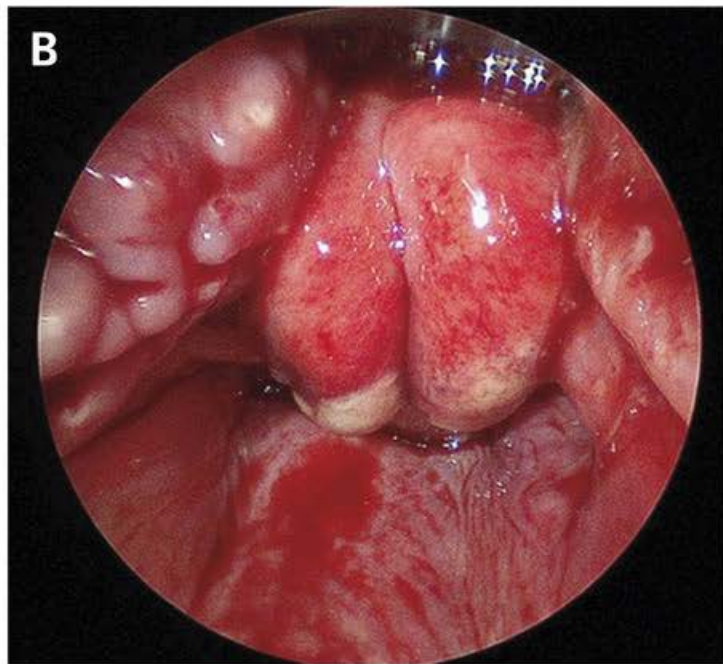
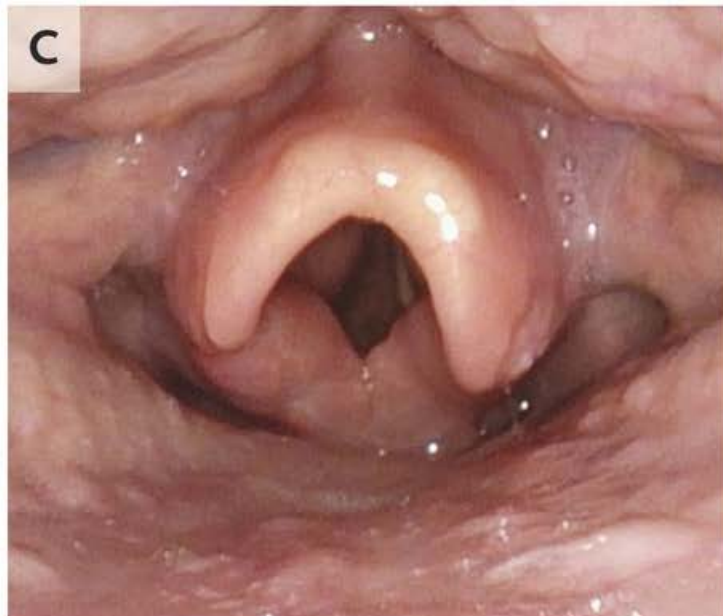
Timing from onset of symptoms to presentation is critical in management.

Managed with airway stabilization, steroids and antibiotics

“Thumb” Sign



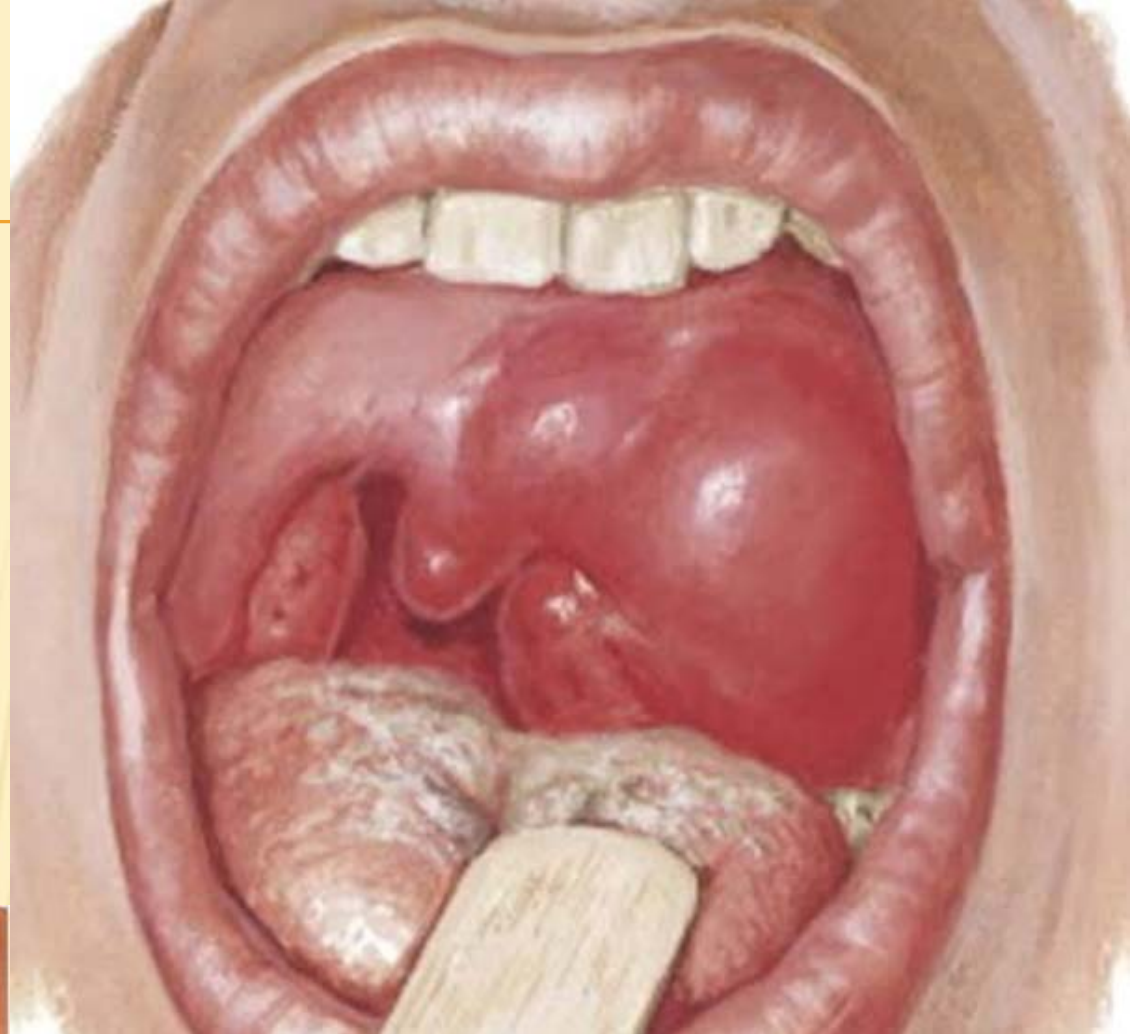


A**B****C**

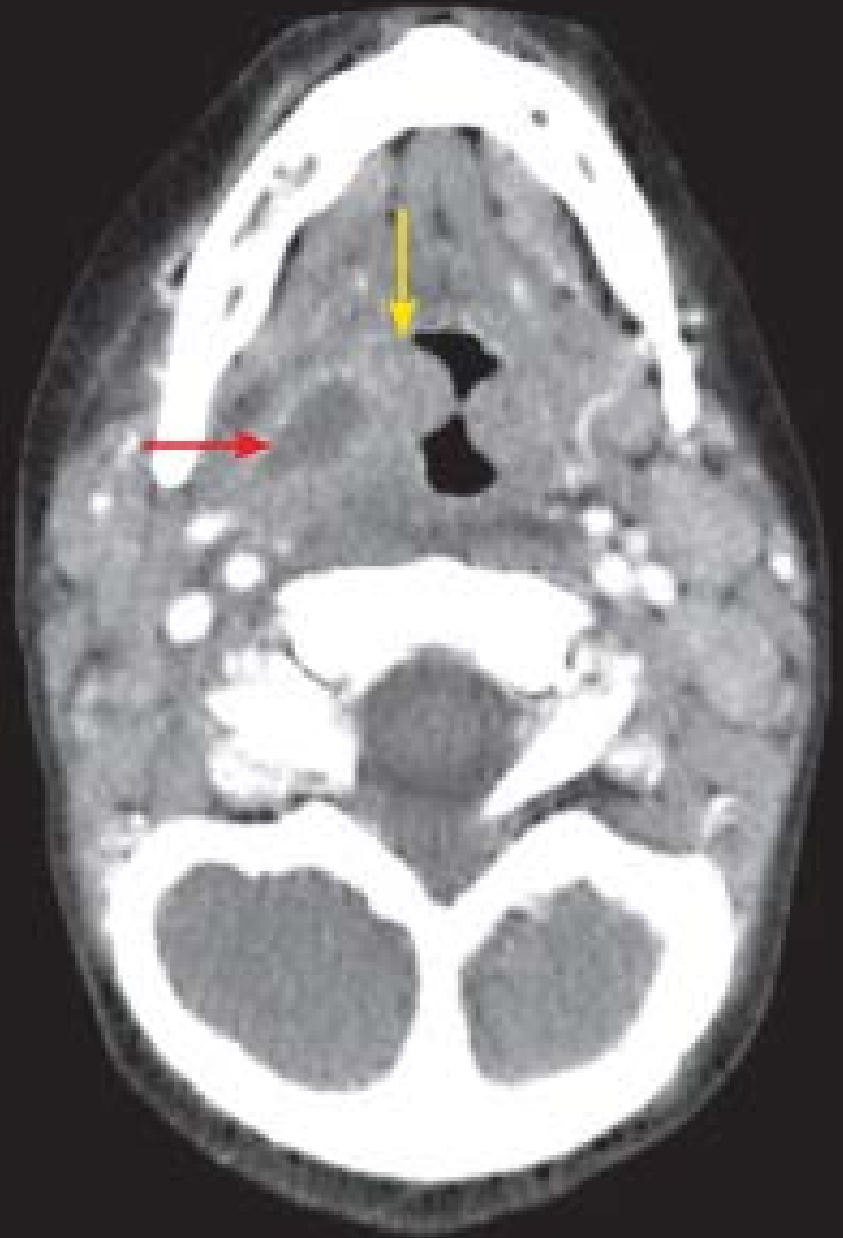
Peritonsillar abscess

1. Trismus
2. Firmness and displacement of tonsil
3. Ultrasound or CT with contrast
4. Drainage
5. Antibiotics

Anatomy



CT PTA

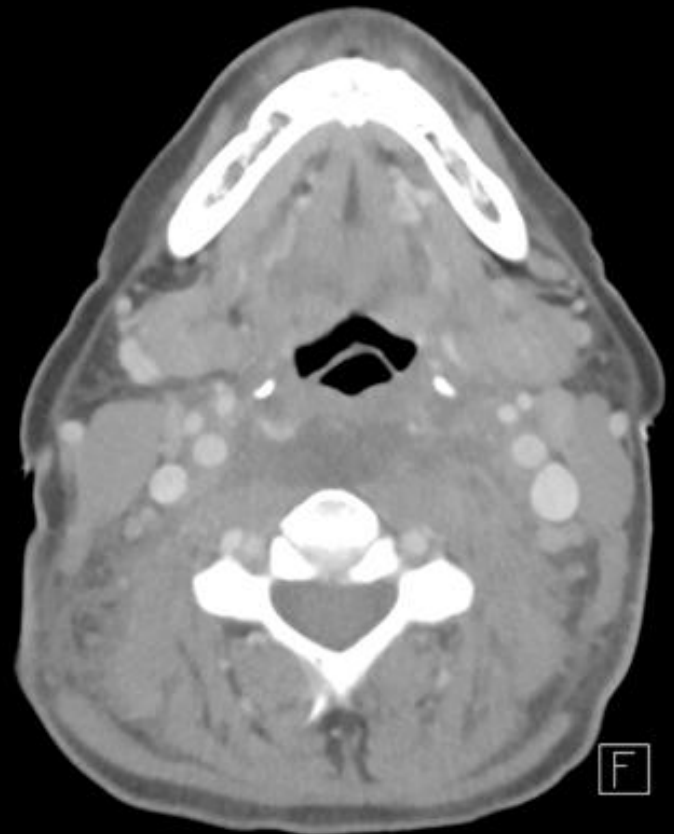


Parapharyngeal/Retropharyngeal abscess

1. Limitation of neck motion
2. CT with contrast
3. Antibiotics and steroids
4. Surgical candidate or not?



Parapharyngeal/Retropharyngeal abscess



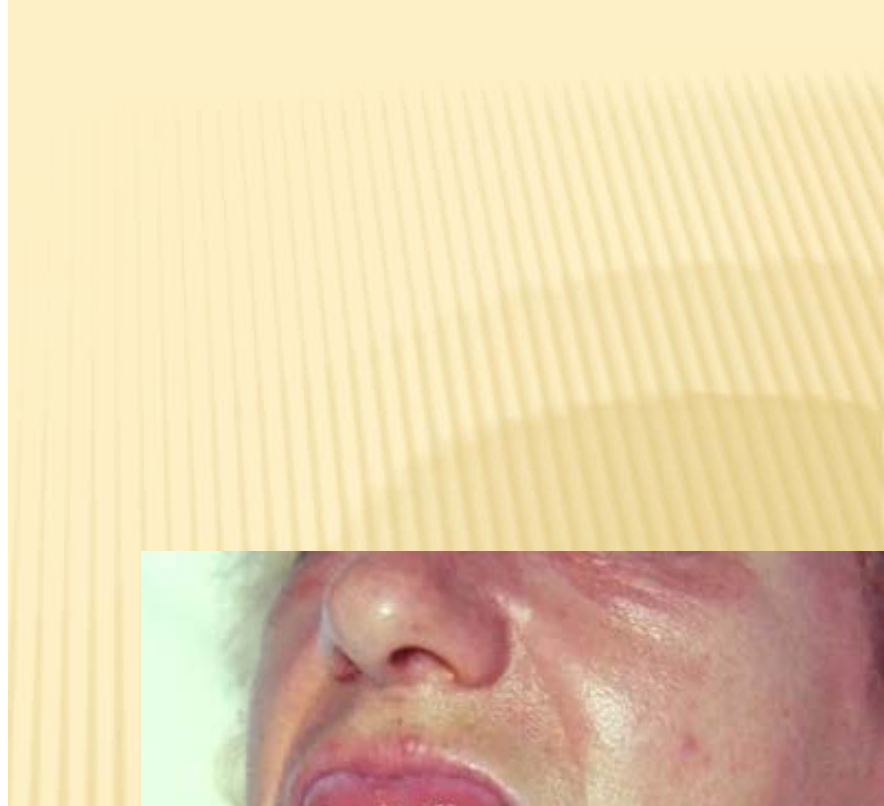


Ludwigs Angina (Cellulitis of Floor of Mouth)

Usually from dental infection that is untreated

Usually cellulitis, no definitive abscess

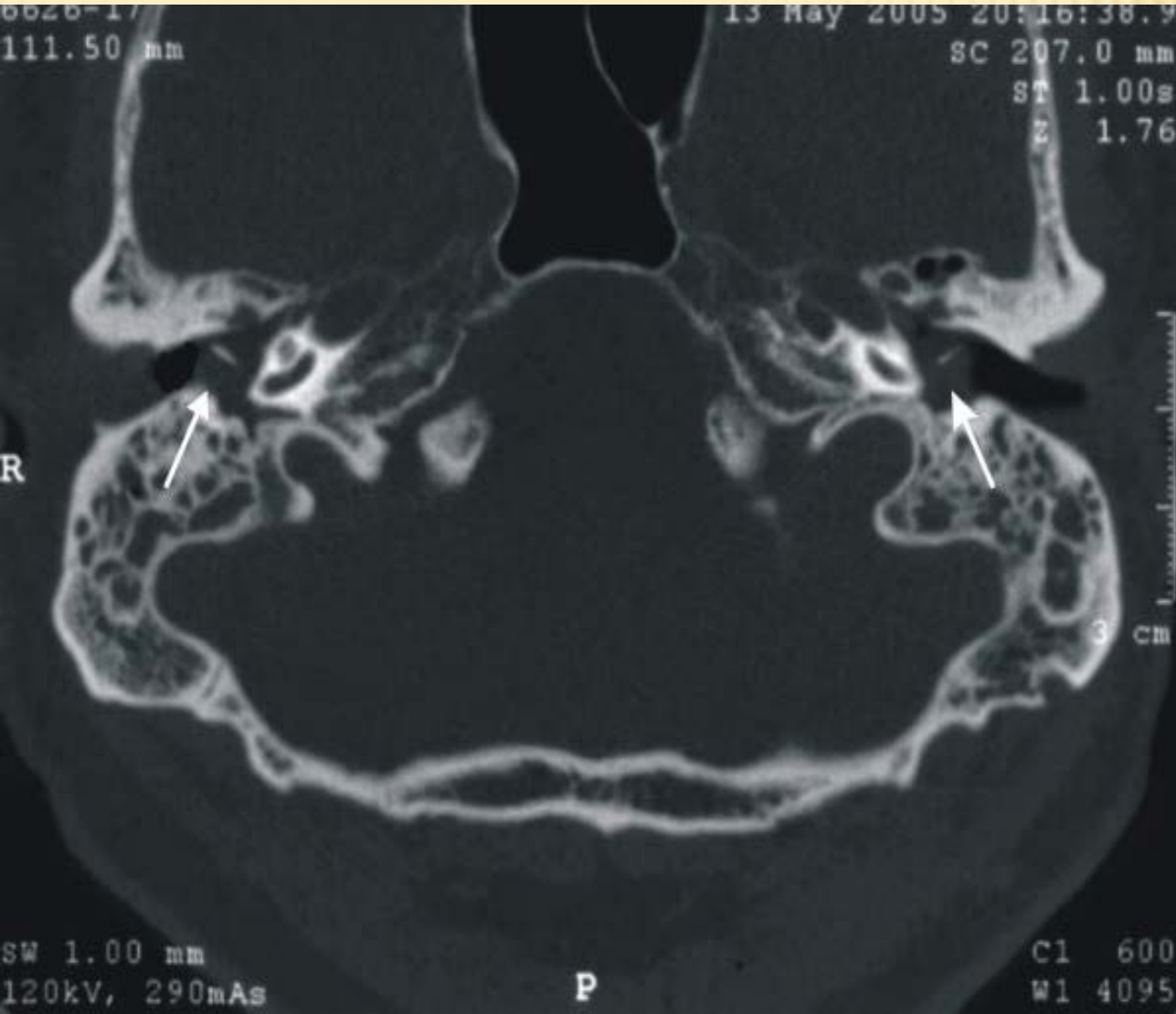
Manage airway, abx, steroids



Mastoiditis/Osteomyelitis)

1. Not all fluid in mastoid is mastoiditis
2. CT evidence of bone destruction
3. Mastoid tenderness with erythema
4. Fever/constitutional symptoms

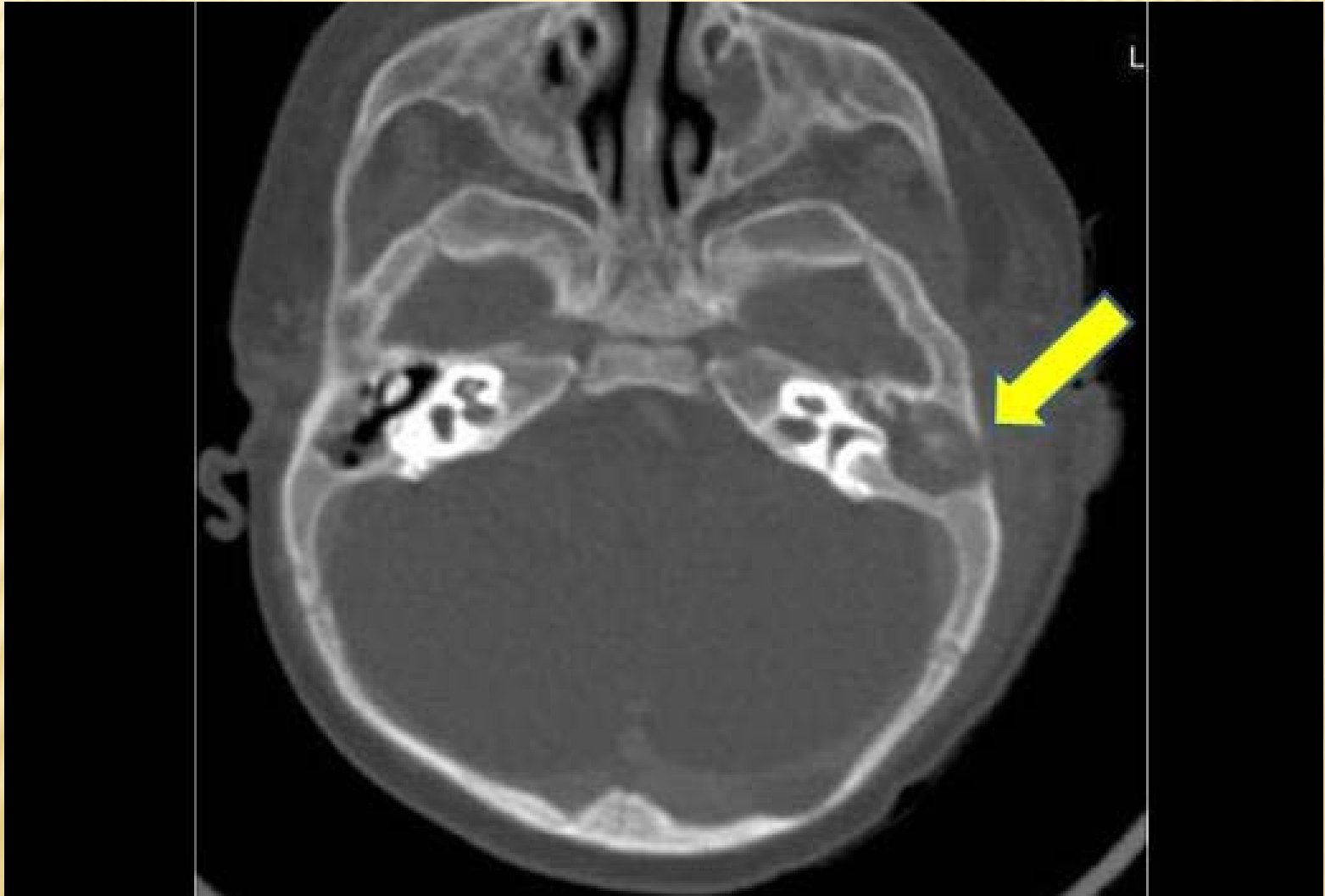
Mastoid fluid



Mastoiditis



Mastoiditis



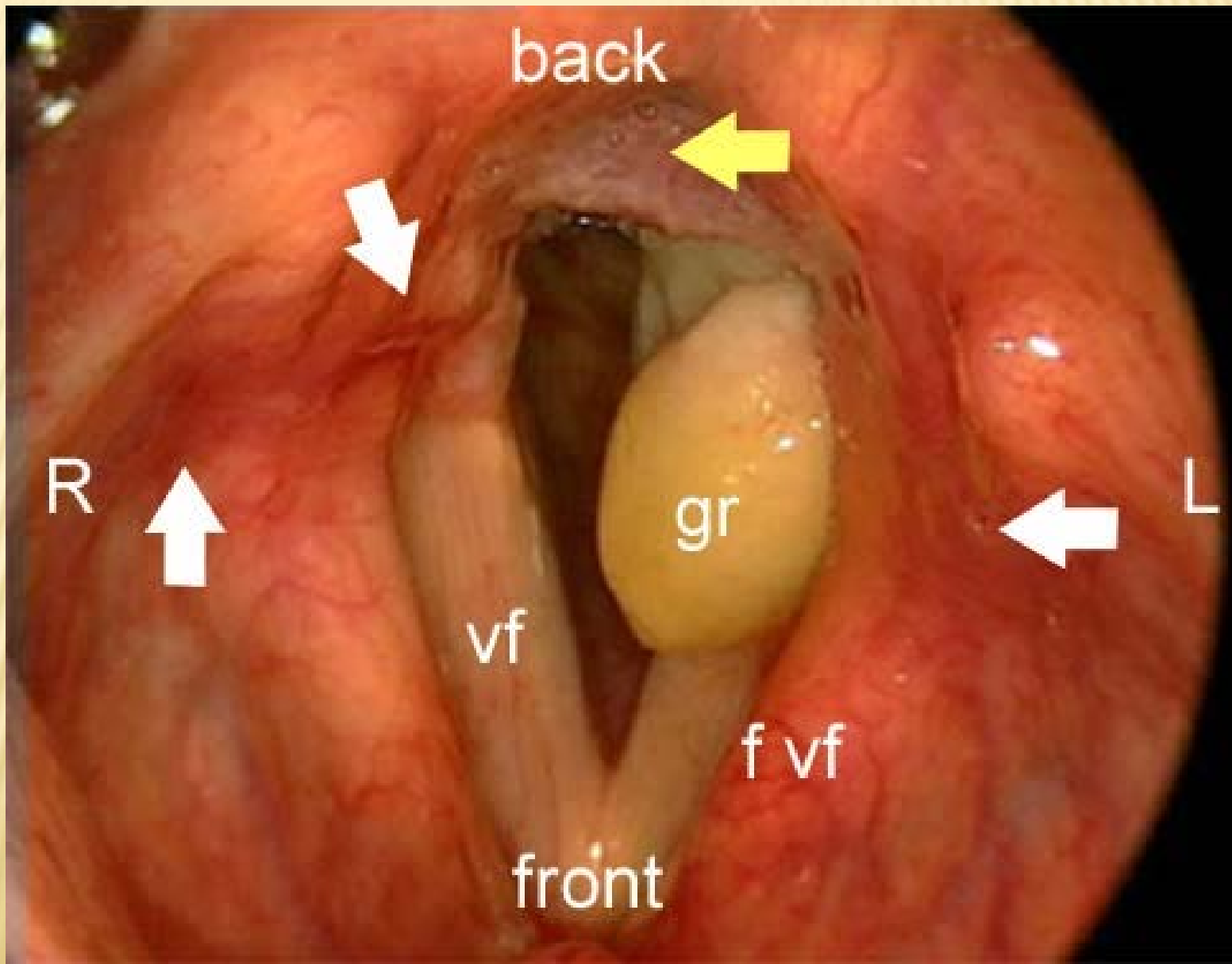
Dysphonia

Voice change that lasts greater than 2 weeks.

Can perform bedside fiberoptic exam.

Must rule out malignant vs benign process.

Granuloma



Dysphonia due to malignancy



Fractures

1. Nasal bone
2. Orbital floor
3. Maxillary
4. Mandible

Nasal fracture

1. If right after injury, reduce in ED
2. Usually fixed within 7-10 days
3. Not emergent
4. No antibiotics needed

Nasal Fracture



Nasal Septal Hematoma

Must be drained as soon as possible.

Nose must be packed afterward.

Remove packing in 24-48 hours.

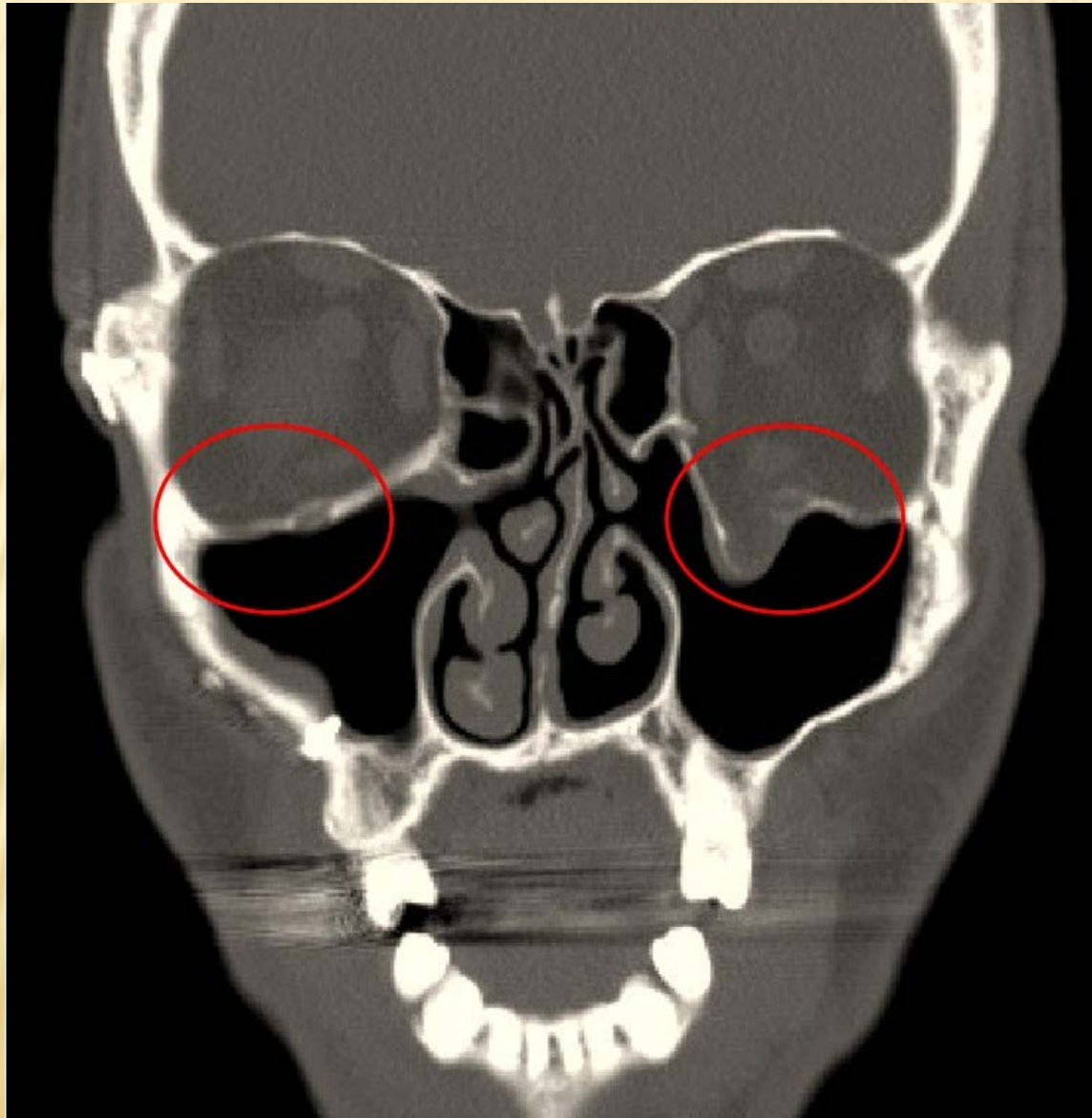
Septal Hematoma



Orbital Floor(Blowout) Fracture

1. Coronal CT
2. Must have Ophthalmology consult!
3. Check for entrapment/double vision
4. Antibiotics and no nose blowing
5. Usually fixed in 2 weeks if necessary

Blowout Fracture

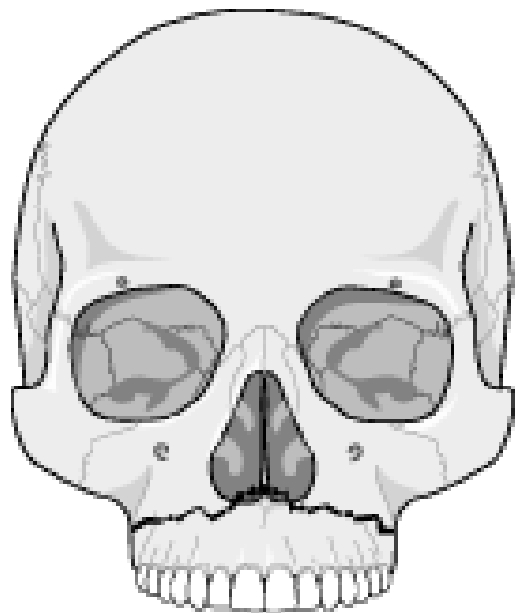


Maxillary Fracture

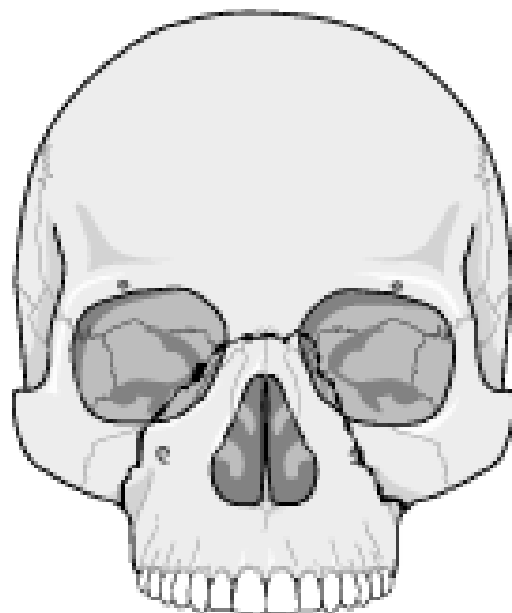
1. CT in Coronal plane
2. Classify
 - a. tripod (no pterygoid involvement)
 - b. LeForte (bilateral with pterygoid involvement)
3. Antibiotics and no nose blowing.
4. Repaired within 10-14 days if necessary



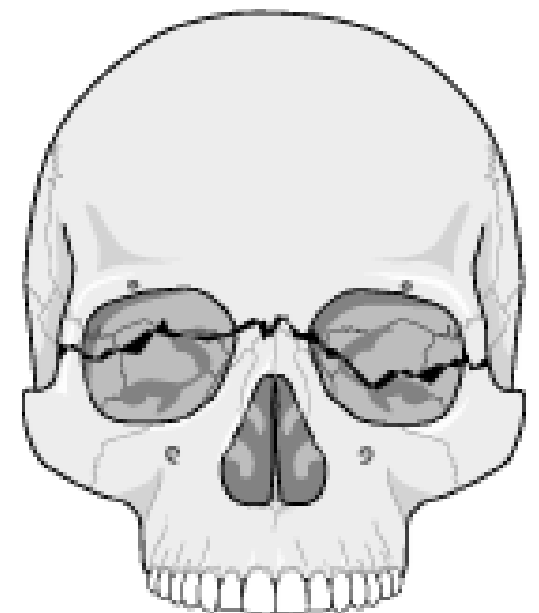
LeForte Fracture



I



II



III

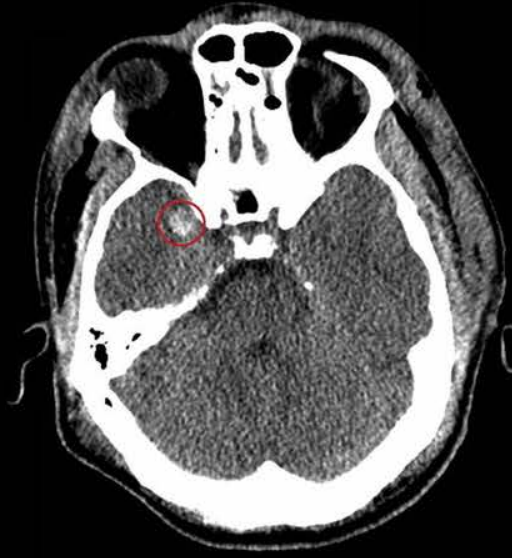


Twenty year old female with Lefort I maxillary fracture and malocclusion.

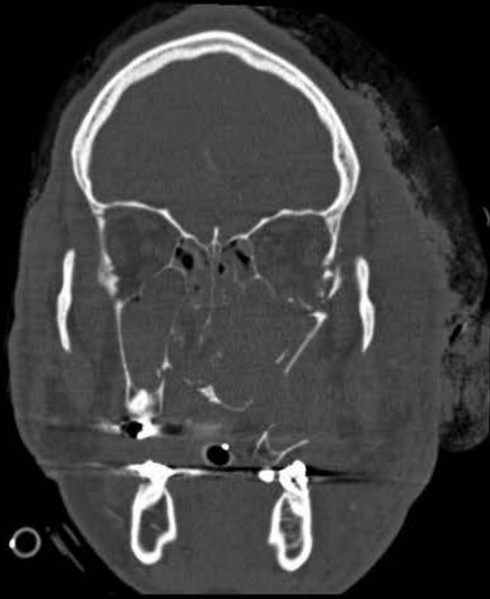


Postoperative result after open reduction and rigid fixation.

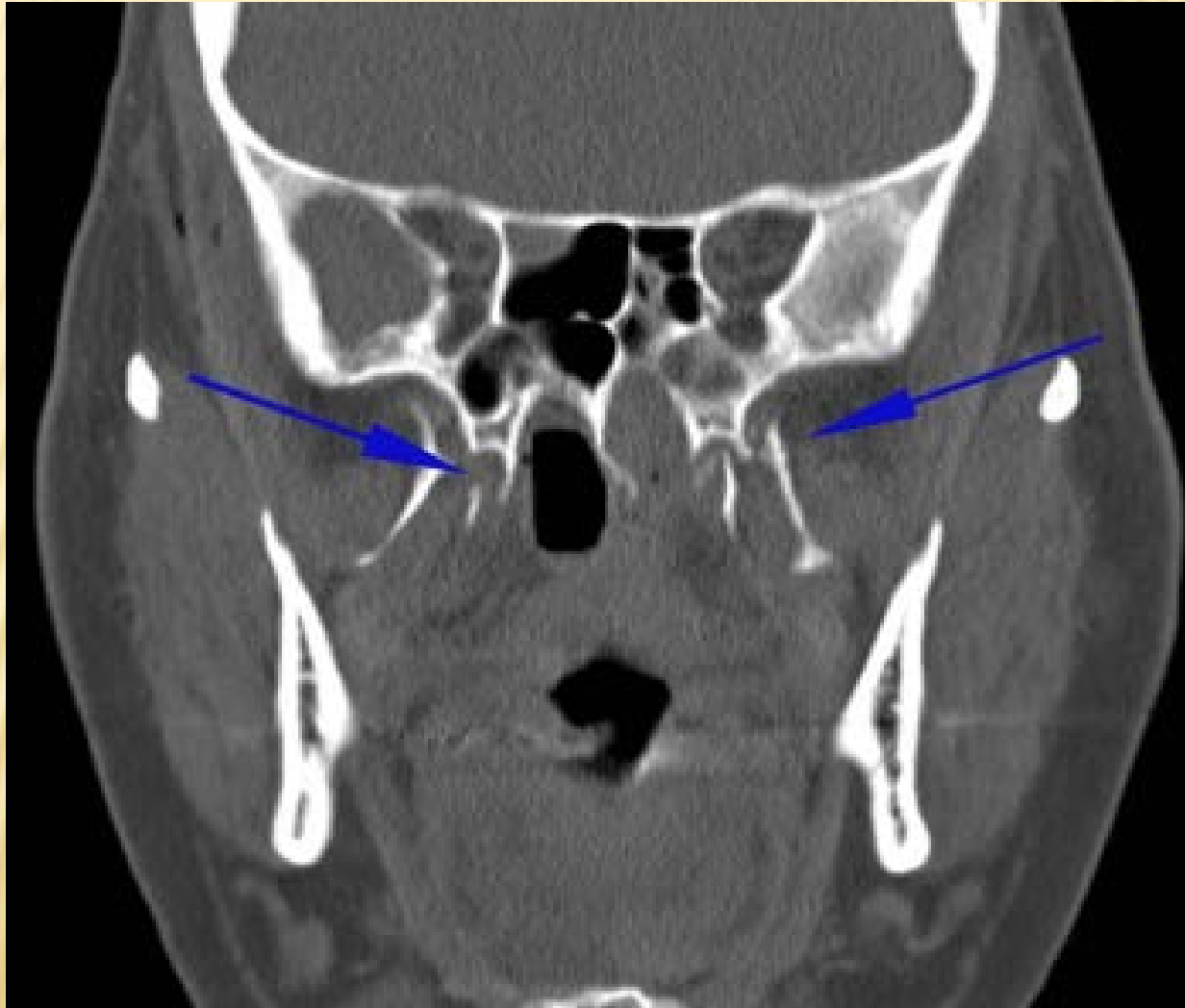
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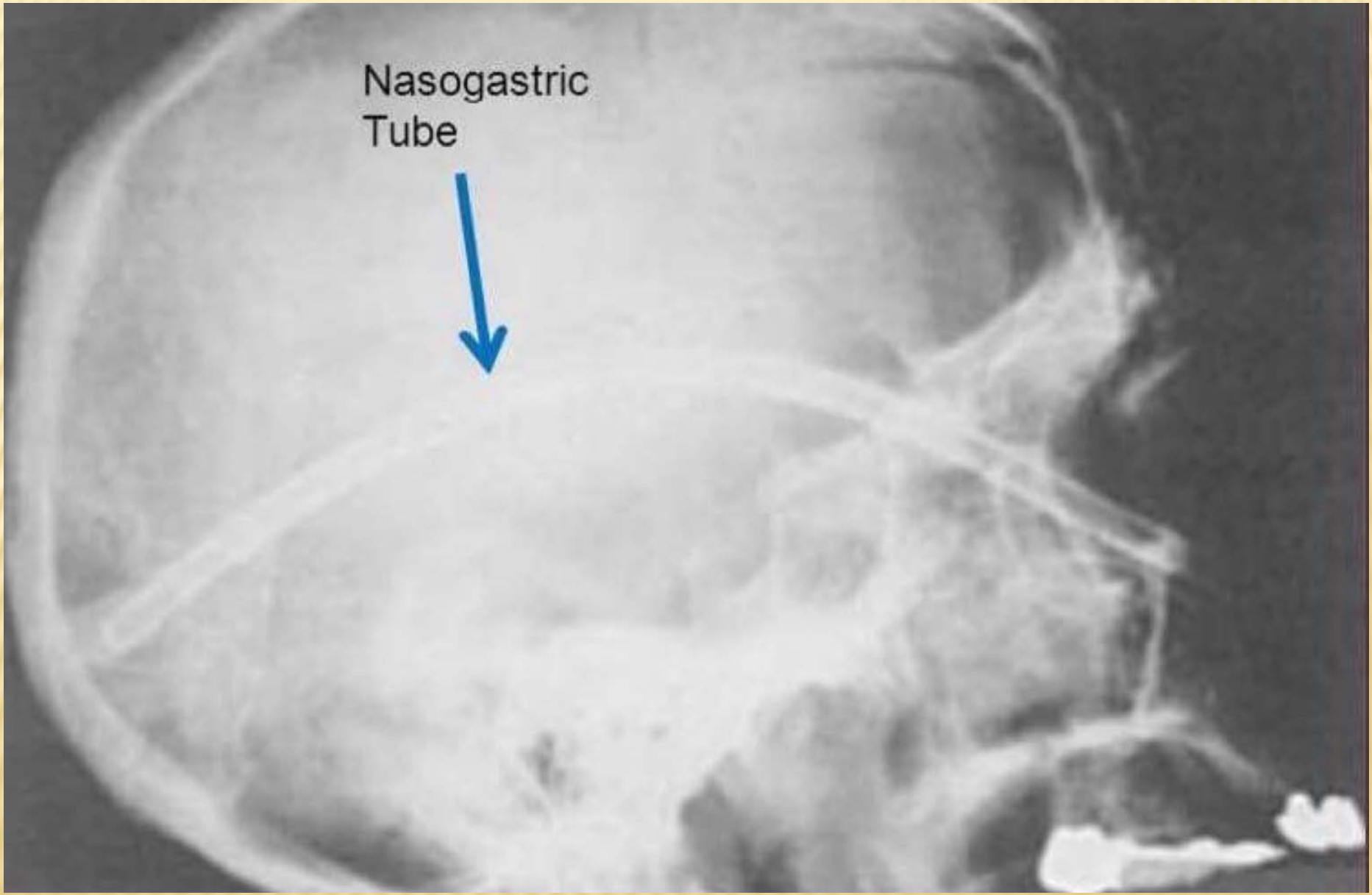
132

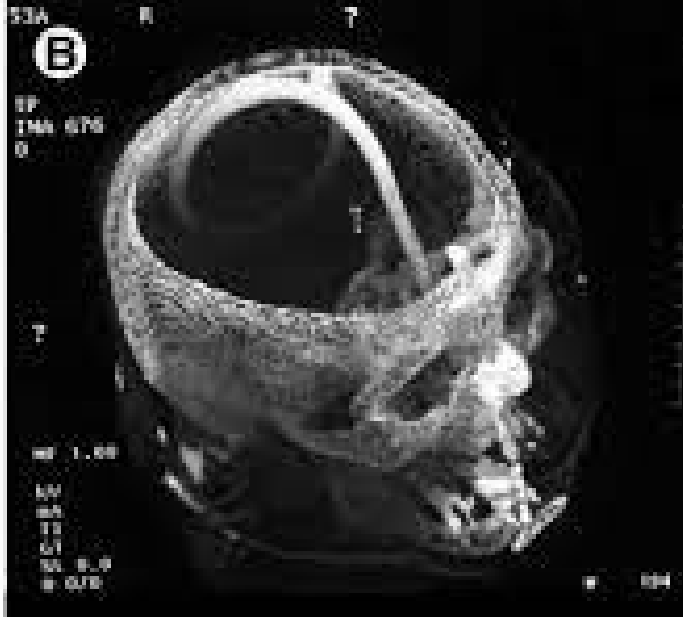


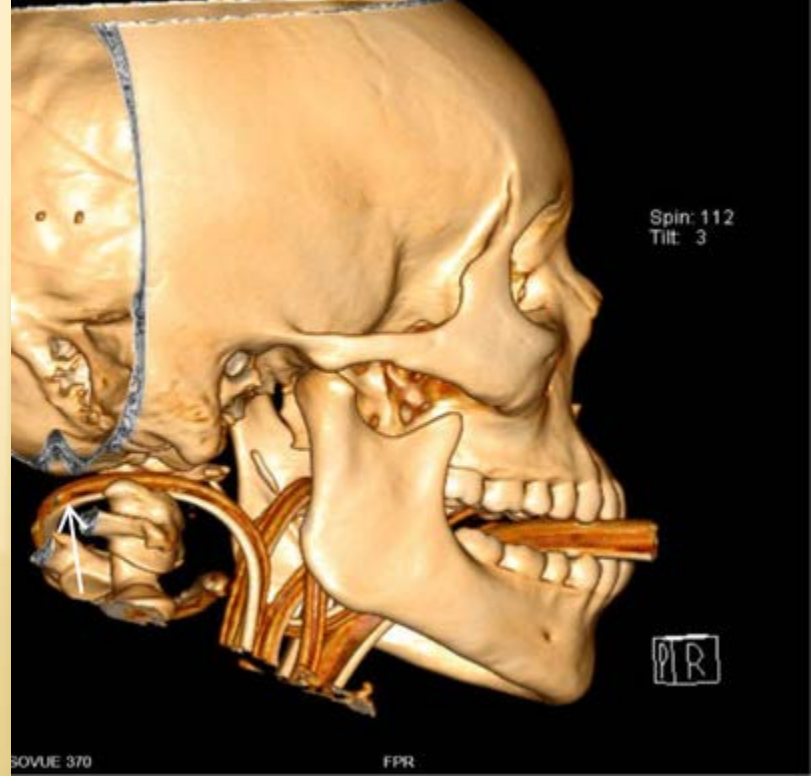
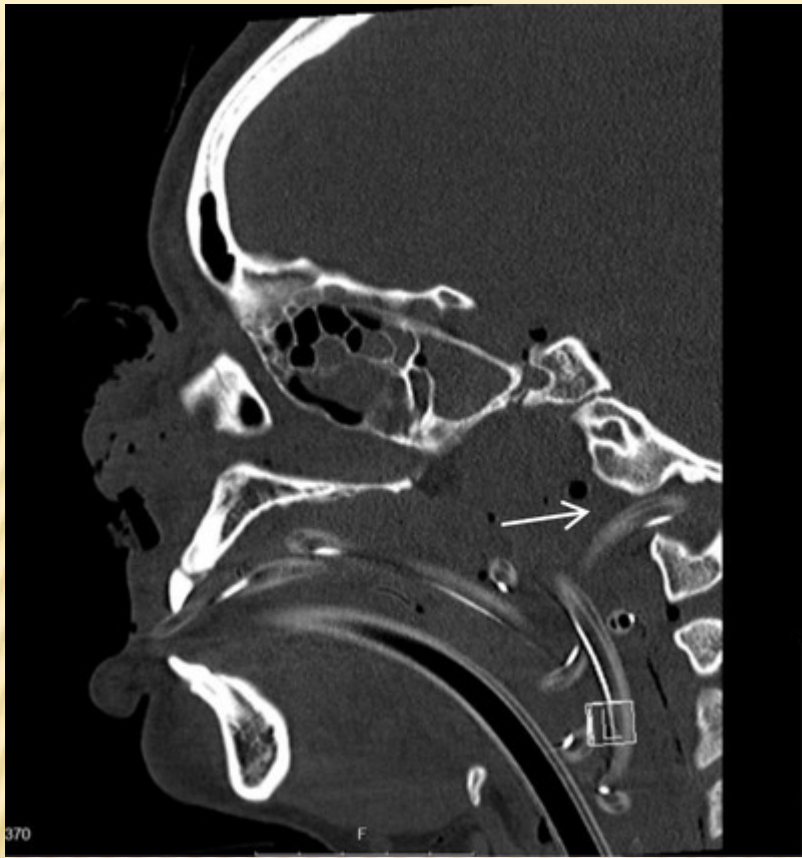
Pterygoids



Nasogastric
Tube



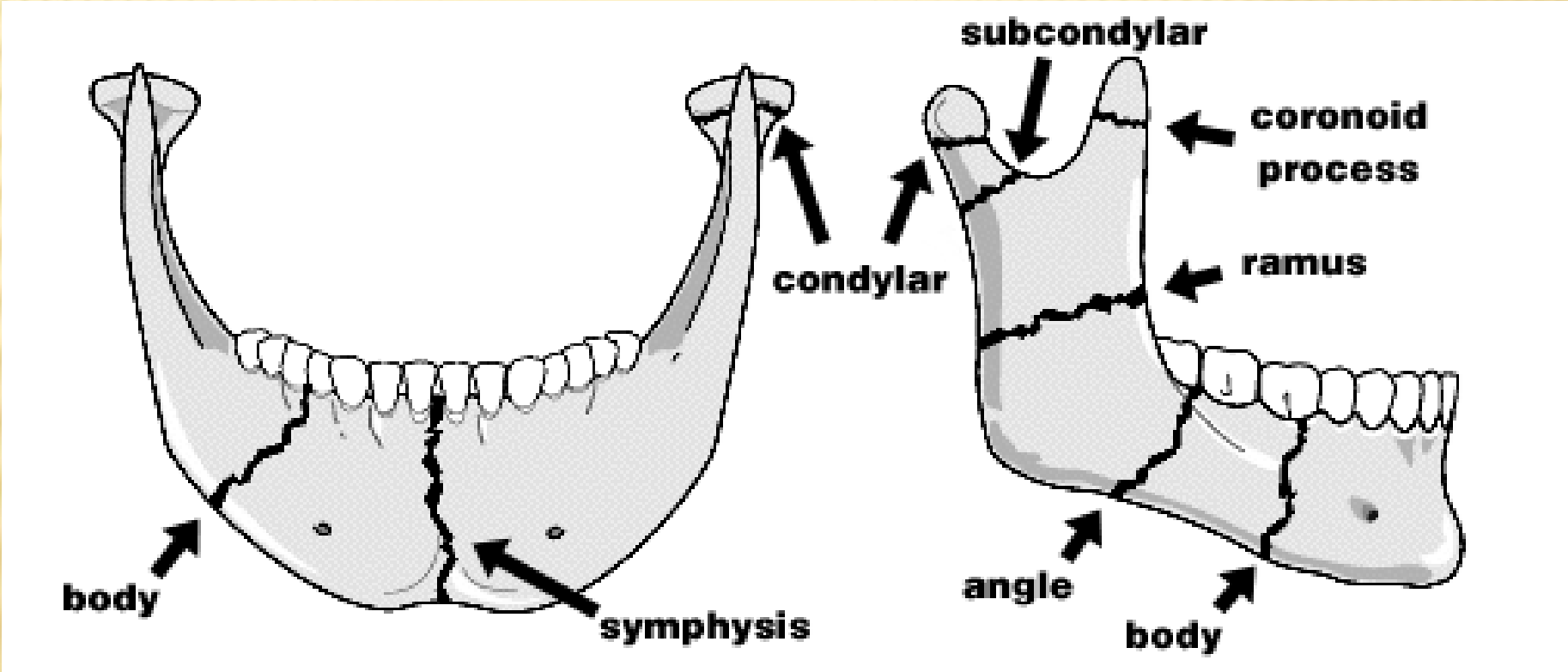




Mandible Fractures

1. CT
2. “Always” 2 fractures
3. Repaired within 2 weeks

Mandible Fracture





Panorex Mandible



RED DOT

Epistaxis

1. Manage underlying pathology
 - a. HTN
 - b. coagulopathy
2. Packing
 - a. Admit or not
 - b. Always antibiotics
3. Interventional Radiology/Embolization

Packing



Insertion



Reality



QUESTIONS?

