Department of Health clinical urgency categories for specialist clinics
Urgent: A referral is urgent if the patient has a condition that has major functional impairment and/or moderate risk of permanent damage to an organ/bone/tissue/system if not seen within 30 days.
Semi Urgent: Referrals should be categorised as Semi Urgent where the patient has a condition that has the potential to deteriorate within 30-90 days.
Routine: Referrals should be categorised as routine if the patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if specialist assessment is delayed beyond one month.
Exclusions: Nil

HEAD AND NECK CONDITIONS (INCLUDING THROAT DISORDERS)

These guidelines have been set by DHHS: src.health.vic.gov.au

Condition / Symptom	Criteria for Referral	Information to be included	Expected Triage Outcome	Austin Specific Guidance Notes
Neck Mass or Lumps Direct to Emergency Department for: **Sudden or new mass or lump associated with difficulty in breathing or swallowing.** • **Sialadenitis with difficulty in breathing.** • **Ludwig's angina (see guidance notes on right)** Immediately contact the vascular registrar to arrange an urgent ENT assessment for: • **Acute inflammatory neck mass with redness, pain or increased swelling.**	1. Confirmed head and neck malignancy. 2. New suspicious solid mass, or cystic neck lumps, present for more than four weeks 3. New suspicious solid mass, or cystic neck lumps, in patents with a previous head / neck malignancy 4. Sialadenitis	Must be provided: 1. CT scan of neck, with contrast where appropriate (preferred) or ultrasound. Provide if available: Any of the following: 1. History of smoking 2. Excessive alcohol intake 3. Full blood count 4. Fine needle aspiration biopsy.	**Urgent**	*Refer to page 7 for Paediatric Neck Mass* GP management: should not routinely prescribe antibiotics unless there are signs & symptoms of bacterial infection Ludwig's angina: this is a cellulitis of the floor of the mouth which can easily cause pharyngeal airway obstruction
Thyroid Mass Direct to Emergency Department for:	1. Suspected or confirmed malignancy. 2. Compressive symptoms:	Must be provided: • Ultrasound with, or without, fine	**Urgent** - FNA positive or suspicious for malignancy - Dominant nodule >4cm	

HEAD AND NECK CONDITIONS (INCLUDING THROAT DISORDERS)				
These guidelines have been set by DHHS: src.health.vic.gov.au				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
• **Thyroid mass with difficulty in breathing or with bleeding from the nodule.** Additional comments: 1. Referrals for patients with hyperthyroidism should be directed to an endocrinology service.	• changing voice • difficulty in breathing • dysphagia • suspicious dominant nodules or compressive neck nodes. 3. Generalised thyroid enlargement without compressive symptoms. 4. Recurrent thyroid cysts. 5. An increase in the size of previously identified benign thyroid lumps > 1cm in diameter. Referral not appropriate for: • Non-bacterial thyroiditis • Uniform, enlarged gland suggestive of thyroiditis without other symptoms	needle aspiration results • Thyroid stimulating hormone (TSH) and free thyroxine (T4) results.	- Compressive sx - Neck nodes positive for malignancy **Semi-urgent** - Generalised thyroid enlargement without compressive sx - Recurrent thyroid cysts **Routine** - Benign	

Salivary Gland Disorder or Mass
 	
Direct to Emergency Department for:
• **Salivary abscess associated with:**
  ○ **swelling in the neck**
  ○ **difficulty in breathing**
 	
Immediately contact the ENT registrar to arrange an urgent ENT assessment for:
• **Acute salivary gland inflammation unresponsive to treatment**
	1. Confirmed or suspected tumour or solid mass in the salivary gland
	2. Symptomatic salivary stones with recurrent symptoms unresponsive to treatment.
		Must be provided:
		• History of symptoms
		• Location of site(s) of mass
		• History of skin cancers removed
		• History of smoking.
		
		Provide if available:
		• Ultrasound results
			Urgent
			- Confirmed or suspected tumour	

HEAD AND NECK CONDITIONS (INCLUDING THROAT DISORDERS)				
These guidelines have been set by DHHS: src.health.vic.gov.au				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
• **Sialadenitis in immunocompromised patients, or facial nerve palsy** Additional Comments: • Referrals for patients with mumps or patients with HIV with bilateral symptoms should be directed to an infectious disease service. • Referrals for patients with Sjogren's syndrome should be directed to a rheumatology service.		• CT scan results.		

Recurrent Tonsillitis
 	
Direct to Emergency Department for:
• **Abscess or haematoma (e.g. peritonsillar abscess or quinsy)**
• **Acute tonsillitis with:**
  ○ **difficulty in breathing**
  ○ **unable to tolerate oral intake**
  ○ **uncontrolled fever.**
• **Post-operative tonsillar haemorrhage.**
	1. Chronic or recurrent infection 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 with halitosis
	• absent from work or studies for four or more weeks in a year.
	2. Suspicious unilateral tonsillar solid mass with or without ear pain.
	
	Referral not appropriate for:
		Must be provided:
		• History of tonsillitis episodes and response to treatment
		• If the patient is taking anticoagulant, or any other medicine that may reduce coagulation, or if there is a family history of coagulation disorder.
			Urgent
			- More than 7 episodes in 1 year
				GP management: treat with antibiotics

HEAD AND NECK CONDITIONS (INCLUDING THROAT DISORDERS)				
These guidelines have been set by DHHS: src.health.vic.gov.au				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
	• If the patient is not willing to have surgical treatment • Halitosis without other symptoms.			

Hoarse Voice (Dysphonia)
 	
Direct to Emergency Department for:
• **Hoarse voice associated with difficulty in breathing or stridor**
• **Hoarse voice associated with acute neck or laryngeal trauma.**
	1. Persistent hoarseness, or change in voice quality, which fails to resolve in four weeks
	2. Recurrent episodes of hoarseness, or altered voice, in patients with no other risk factors for malignancy.
		Must be provided:
		• Duration of symptoms.
		
		Provide if available
		• If patient is a professional voice user
		• Any of the following:
		  ○ History of smoking
		  ○ Excessive alcohol intake
		  ○ Recent intubation
		  ○ Recent cardiac or thyroid surgery
			Urgent
			- If symptoms persisting over 4wks &
			- any of following:
			• History of smoking
			• Excessive alcohol
			• Recent intubation/previous tracheostomy
			• Recent cardiac or neck surgery
			
			Semi-Urgent
			- Recurrent symptoms in patients with no risk factors
				GP Management:
				
				Commence where indicated:
				- Rest voice
				- Antibiotics
				- Inhalant steroid sprays
				- Humidification
				- Smoking cessation
				- Reduce caffeine intake

Dysphagia (ENT) Direct to Emergency Department for: • **Sudden onset of inability to swallow** • **Inability to swallow**	1. Oropharyngeal or throat dysphagia with either: • hoarseness • progressive weight loss • history of smoking • excessive alcohol intake.	Must be provided: • History of symptoms over time • History of smoking • History of excessive alcohol intake.	**Urgent** Suspicion of oropharyngeal lesion - Hoarseness - Unilateral otalgia - Progressive weight loss - Smoker	GP Management: Consider referring to Speech Pathologist +/- Neurology

HEAD AND NECK CONDITIONS (INCLUDING THROAT DISORDERS)				
These guidelines have been set by DHHS: src.health.vic.gov.au				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
• **Swallowing problems accompanied by difficulty in breathing or stridor** • **Difficulty in swallowing caused by a foreign body or solid food.** Additional Comments: • Referrals for oesophageal dysphagia should be directed to a gastroenterology service provided by the health service.	2. Progressively worsening oropharyngeal or throat dysphagia 3. Inability to swallow with drooling or pooling of saliva.		- Excessive alcohol intake Significant dysphagia + - Gagging/choking/coughing on swallowing - Food or liquid regurgitation - Recurrent chest infections	
Vertigo (ENT) Direct to Emergency Department for: • **Sudden onset debilitating vertigo where the patient is unsteady on their feet or unable to walk without assistance** • **Barotrauma with sudden onset vertigo, or symptoms suggestive of stroke or transient ischaemic attacks.** Additional Comments:	1. Vertigo that has not responded to vestibular physiotherapy treatment.	Must be provided: • Results of diagnostic vestibular physiotherapy assessment or Epley manoeuvre • Results of diagnostic audiology assessment • Onset duration and frequency of vertigo. Provide if available Description of any of the following: • Functional impact of vertigo • Any associated otological or	**Routine** - BPPV refractory to repeated repositioning manoeuvre or after seeing vestibular physiotherapist	GP Management: • Important to rule out central causes • Consider possible causes (migraine, medications, orthostatic or cardiac) • If Dix Hallpike Test positive, perform repositioning manoeuvre (Epleys, log roll) • Consider referring for vestibular physiotherapy Consider safety, falls prevention

HEAD AND NECK CONDITIONS (INCLUDING THROAT DISORDERS)				
These guidelines have been set by DHHS: src.health.vic.gov.au				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
• Chronic or episodic vertigo and vertigo with other neurological symptoms should be directed to a neurology service.		neurological symptoms • Any previous diagnosis of vertigo (attach correspondence) • Any treatments (medication or other) previously tried, duration of trial and effect • Any previous investigations or imaging results • Hearing or balance symptoms • Past history of middle ear disease or surgery. History of any of the following: • Cardiovascular problems • Neck problems • Neurological • Auto immune conditions • Eye problems • Previous head injury. • Description of hearing loss or change in hearing.		

HEAD AND NECK CONDITIONS (INCLUDING THROAT DISORDERS)				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
Paediatric Neck Mass		**Clinical history & examination:** Detailed history of mass **Imaging:** US +/- FNA, MCS, AFB, no CT neck **Diagnostics:** FBE, CRP, EBV, CMV serology Consider Bartonella serology, Toxoplasmosis, HIV titre if indicated	**Urgent** - Increasing size - Not responding to antibiotics - Persisting > 6 weeks **Semi-urgent** - Suspected thyroid mass - All other neck masses	
Acute Tonsillitis Emergency Department for: • **Not tolerating oral intake** • **Airway concerns** • **Evidence of peritonsillar abscess/quinsy**		**Clinical history & examination:** Frequency of attacks, previous peritonsillar abscess/quinsy, any bleeding history **Diagnostics:** Not routinely indicated		GP Management: • Treat with antibiotics (as per Antibiotic Therapeutic Guidelines)

HEAD AND NECK CONDITIONS (INCLUDING THROAT DISORDERS)				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
Peritonsilar Cellulitis Peritonsillar Abscess / Quinsy Emergency Department for: • **Not tolerating oral intake** • **Airway issues** • **Evidence of abscess/quinsy**		**Clinical history & examination:** Stridor, voice change, trismus, airway concerns		GP Management: • Treat with antibiotics (as per Antibiotic Therapeutic Guidelines)
Infectious Mononucleosis Viral Pharyngitis Emergency Department for: • **Not tolerating oral intake** • **Airway issues** • **Evidence of quinsy**		**Clinical history & examination** **Diagnostics:** Monospot test / EBV serology FBE, UE, CRP		GP Management: • Monospot / EBV serology if suspect EBV tonsillitis
Neoplasm **Please call ENT Registrar via Austin Switchboard to discuss**		**Clinical history & examination** Risk factors: smoking, alcohol intake, airway issues, previous malignancy **Diagnostics:** CT neck (with contrast), US neck + FNA		GP Management: • Treat with antibiotics (as per Antibiotic Therapeutic Guidelines)

HEAD AND NECK CONDITIONS (INCLUDING THROAT DISORDERS)				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
Facial Paralysis		**Clinical history & examination** Immediate vs delayed, complete vs incomplete, trauma, surgery, otological sx, hx of skin or head/neck malignancy **Diagnostics:** If relevant, CT temporal bone/neck, Audiogram	**Urgent** - Lower motor neuron + hearing loss/otalgia/otorrhea/other cranial nerve palsy - Vesicles in ear or oral cavity - Perineural spread from cutaneous SCC - No improvement or worsening palsy despite treatment	GP Management: • Eye protection if incomplete colsure - Lacrilube & tape eye shut nocte • If suspicious of Bell's palsy or Ramsay Hunt Syndrome, - Commence oral prednisolone 1mg/kg (50mg for 10 days) if no contraindications, within 72 hours of onset - Oral antivirals in addition to oral prednisolone, prescribe within 72 hours of onset, do not prescribe antiviral alone (?only if vesicles seen)

EARS				
These guidelines have been set by DHHS: src.health.vic.gov.au				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
Discharging Ear Immediately contact the ENT registrar to arrange an urgent ENT assessment for: • **Ear discharge with moderate to severe persistent ear pain, persistent headache, cranial nerve neuropathy or facial palsy** • **Malignant otitis externa (see guidance note on right)** • **Suspected skull base osteomyelitis** • **Cellulitis of the pinna** • **Suspected mastoiditis** • **Osteitis ear.** Additional Comments: • Referrals for other forms of obstructive sleep apnoea should be directed to a multidisciplinary sleep clinic or respiratory service.	1. Non-painful discharging ear for longer than two weeks that fails to settle with treatment. 2. Otorrhea clear discharge 3. Cholesteatoma. Referral not appropriate for: • Waxy ear discharge	Must be provided: • Microscopy, culture and sensitivity (MCS) ear swab. Provide if available • History of smoking • Excessive alcohol intake.	FOR ENT to advise	Maglinant otitis externa - this is an otitis externa with discharge often in a patient with diabetes or other cause of being immunocompromised
Bilateral or Asymmetrical Hearing Loss Direct to Emergency Department for an	1. Asymmetrical hearing loss with significant impact on the patient	Must be provided: • Results of diagnostic	**Urgent** - Rapid progressive severe unilateral or bilateral SNHL	GP Management: • If wax, use cerumen

EARS				
These guidelines have been set by DHHS: src.health.vic.gov.au				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
ENT assessment and commencement of treatment: • **Sudden onset hearing loss in the absence of clear aetiology** • **Sudden hearing loss due to trauma or vascular event** • **Sudden, profound hearing loss.** Additional Comments: • Referrals for other forms of obstructive sleep apnoea should be directed to a multidisciplinary sleep clinic or respiratory service.	2. Sensorineural hearing loss confirmed by diagnostic audiology assessment 3. Symmetrical hearing loss caused by ototoxic medicine(s) Referral not appropriate for: • Symmetrical gradual onset hearing loss • Symmetrical age-related hearing loss • Patients with a normal audiogram.	audiology assessment. Provide if available • Description of hearing loss or change in hearing.	- Unilateral vertigo/tinnitus **Routine** Bilateral severe to profound HL & any of following: - Poor speech discrimination - Does not receive adequate benefit from hearing aids - Chronic HL	dissolving drops (Waxol, Hydrogen Peroxide) • For hearing aid users, refer to local hearing aid provider to ensure optimal hearing aid fitting • If sudden sensorineural hearing loss & no contraindications, start oral prednisolone 1mg/kg up to 60mg/kg daily
Tinnitus	1. Recent onset of unilateral tinnitus 2. Pulsatile tinnitus present for more than six months. Referral not appropriate for:	Must be provided: • Results of diagnostic audiology assessment.	**If pulsatile: Urgent to rule out tumour** **If non-pulsatile Urgent** - Vertigo - Hearing loss - Otalgia - Otorrhea	**If non-pulsatile** GP Management: • Clear cerumen

EARS				
These guidelines have been set by DHHS: src.health.vic.gov.au				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
	• Patients with a normal audiogram.		- Recent Barotrauma **Routine** - Chronic bilateral	

EARS				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
Acute Otitis Media Refer to ED if • **Facial nerve palsy** • **Acute mastoiditis** • **Subperiosteal abscess (pinna protrusion)** • **Meningitis/encephalitis**		**Clinical history & examination** otalgia, fever, otorrhea **Diagnostics:** Ear swab MCS if discharging	**Semi-urgent** - Cholesteatoma - Recurrent AOM - Syndromic, craniofacial abnormalities, cleft palate **Routine** - AOM with TM perforation with persisting concerns >6weeks - Recurrent AOM (>3 episodes in 6 months or > 4 episodes in 12 month)	GP Management: • Oral antibiotics • Analgesia
Otitis Media with Effusion ('Glue Ear')		**Clinical history & examination** URTI, hearing loss, speech/developmental delay, indigenous background **Diagnostics:** Ear swab MCS if discharging	**Semi-urgent** - TM abnormalities (choelsteatoma, TM retraction) - Speech / developmental delay - Severe hearing loss **Routine** - Mild hearing loss	

EARS				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
Acute Otitis Externa		**Clinical history & examination** Otalgia, otorrhea **Diagnostics:** Ear swab MCS, including fungus	**Urgent** - Confirmed otitis externa & persistent sx & pain - Hearing loss despite maximal medical management **Semi-urgent** - Confirmed otitis externa without pain	GP Management: • Insert ear wick if canal oedematous • Avoid syringing • Water precautions • Avoid using hearing aids • Topical Sofradex drops for bacterial infection & Locacorten Vioform drops for fungal infection
Foreign Body (ear/nose) Refer to ED if • **Suspicion of button battery** • **ingestion/inhalation**		**Clinical history & examination** Type of foreign body, duration	**Urgent**	GP Management: • Remove if only technically able, stop immediately if any bleeding

NOSE & SINUS				
These guidelines have been set by DHHS: src.health.vic.gov.au				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**

Rhinosinusitis
 	
Direct to Emergency Department for:
• **Complicated sinus disease with:**
  ○ **orbital and / or neurological signs**
  ○ **severe systemic symptoms**
  ○ **periorbital oedema or erthyema**
	1. New and persistent unilateral nasal obstruction present for more than four weeks
	2. Rhinosinusitis that has not responded to three months of intranasal steroid and nasal lavage treatment.
	
	Referral not appropriate for:
		Must be provided:
		
		• Presence of epistaxis
		• Details of previous medical management including the course of treatment (e.g. intransal steroid, nasal lavage or
			FOR ENT to advise	

NOSE & SINUS				
These guidelines have been set by DHHS: src.health.vic.gov.au				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
○ **altered visual acuity, diplopia, or reduced eye movement.**	• Patients with headaches who have a normal CT scan which has been performed when the patient has symptoms • Patients who have not had three months of intranasal steroid and nasal lavage treatment.	antibiotics) and outcome of treatment.		
Acute Nasal Fracture Direct to Emergency Department for an ENT assessment: • **Acute nasal fracture with septal haematoma.** • **A new injury where the nose is bent, there is a compound fracture or epistaxis that fails to settle.** Please refer within a week of the injury and indicate the date and mechanism of the injury. Additional Comments: • As patients with an acute nasal fracture should be referred to an appropriate emergency department for ENT assessment, public hospital specialist clinics should not receive any referrals for this presenting problem.	1. Not applicable Referral not appropriate for: • The nose is not bent, or there is no new deformity, or there is no obstruction.	Not applicable	FOR ENT to advise	

NOSE & SINUS				
These guidelines have been set by DHHS: src.health.vic.gov.au				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
Obstructive Sleep Aponea Immediately contact the ENT registrar to arrange an urgent ENT assessment for: • **Rapid progression of obstructive sleep aponea** Additional Comments: • Referrals for other forms of obstructive sleep apnoea should be directed to a multidisciplinary sleep clinic or respiratory service.	1. Obstructive sleep apnoea with: • Nasal obstruction • Macroglossia.	Must be provided: • History of symptoms over time and burden of symptoms, sleep quality (especially the story from partner), waking during the night and level of tiredness (including Epworth Sleepiness Scale) • Patient's weight • If the patient is taking an antidepressant medicine. Provide if available Recent polysomnography results.	FOR ENT to advise	

NOSE & SINUS				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
Epistaxis – persistent or recurrent Refer to ED if • **Large volume epistaxis** • **Haemodynamically unstable**		**Clinical history & examination:** Anticoagulants, bleeding disorder Laterality, anterior or posterior,	**Urgent** - Suspicion of tumour **Semi-urgent** - Unilateral epistaxis in adolescent male/suspicion of juvenile nasopharyngeal angiofibroma (JNA) **Routine** - Not responding to maximal medical treatment (topical cream, cautery)	GP Management: First aid: Sustained pressure on nostrils Head forward Icing Control SBP <140 Consider cautery with silver nitrate (in setting anticoagulation?) Nasal precautions - No nose picking / blowing - Avoid straining / heavy lifting - Nasal cream (eg. Vaseline, paw paw cream)
Acute Sinusitis Refer to ED if any complications • **Periorbital cellulitis** • **Orbital abscess** • **Rapidly evolving symptomatology in immunosuppressed patient**		**Clinical history & examination** **Imaging:** CT sinuses (non-contrast)	**Urgent** - Treatment not successful **Routine** - Treatment relieving symptoms	GP Management: • Treat acute bacterial infection (Augmentin DF) • Nasal decongestant spray (max 5 days) • Intranasal saline irrigations • Intranasal steroid spray • Consider course of oral steroids (3 weeks)

NOSE & SINUS				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
Chronic Sinusitis/Polyposis		**Clinical history & examination** **Imaging:** CT sinuses (non-contrast)	**Routine** - Chronic & recurrent not responding to maximal medical management	GP Management: • Treat acute bacterial infection (Augmentin DF) • Nasal decongestant spray (max 5 days) • Intranasal saline irrigations • Intranasal corticosteroid spray • Consider course of oral steroids (3 weeks) • Treat asthma, underlying allergies & consider referral to Allergy/Immunology Unit
Facial Pain		**Clinical history & examination:** Nasal sx (obstruction, anosmia, nasal discharge), TMJ dysfunction, Dental hx, Migraine **Imaging:** CT sinuses (non-contrast) (if nasal symptoms)	**Routine** - Consider referral to neurology +/- dentist in the absence of nasal symptomatology or normal CT sinus	

NOSE & SINUS				
Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
Nasal Congestion /Obstruction		**Clinical history & examination:** Document symptoms, duration & treatments trialled **Imaging:** Consider skin prick/RAST/IgE CT sinuses (non-contrast)	**Urgent** - Unilateral polyps - Bloody discharge **Routine** - Bilateral polyps - Allergic rhinitis not responding to maximal medical management	GP Management: • Manage co-existing allergies /asthma • Antihistamine for allergic rhinitis • Saline rinse/irrigation • Intranasal steroid sprays (e.g. mometasone)
Adenoiditis		**Clinical history & examination** Nasal obstruction, nasal discharge, systemic features **Diagnostics:** Imaging not indicated	**Urgent** - Severe symptoms present directly to ED	GP Management: • Treat with antibiotics (as per Antibiotic Therapeutic Guidelines)
Foreign Body (ear/nose) Refer to ED if • **Suspicion of button battery** • **ingestion/inhalation**		**Clinical history & examination** Type of foreign body, duration	**Urgent**	GP Management: • Remove if only technically able, stop immediately if any bleeding