April GP Study Day – ENT Panel

Sat 18th April 2026 – O'Reilly Hall, UCD

Mr Brendan Fennessy
Clinical Lead
Consultant ENT Surgeon

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THE TEAM - 12 SPECIALIST ENT CONSULTANT

Natalija Snovak

Robbie Woods

Brendan Fennessy

Emma Cashman

Paul Burns

Neville Shine

Edlir Shytaj

Phoebe Roche

John Kinsella

Kambiz Golchin

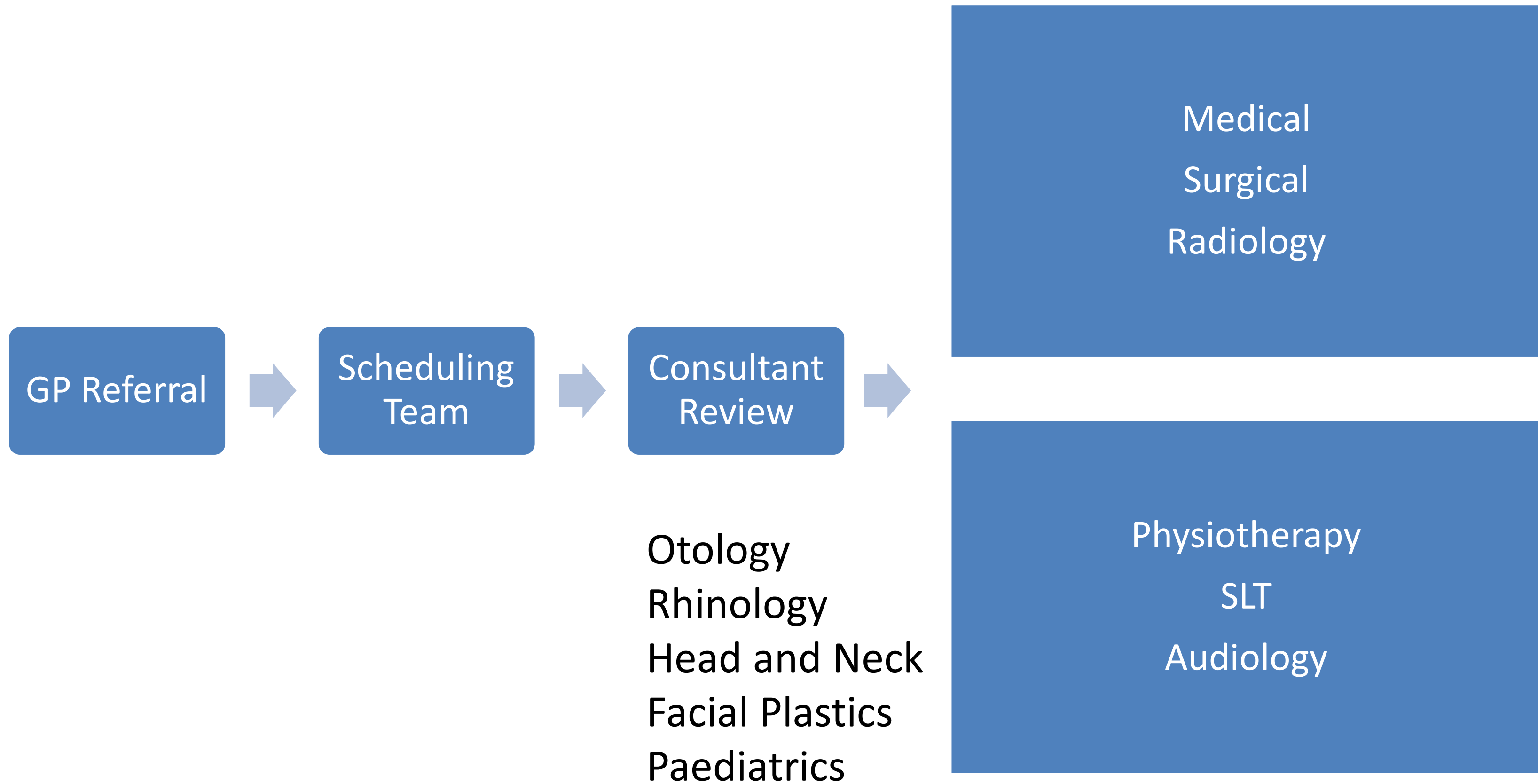
Deidre Fitzgerald

Shawkat Abdulrahman

Patient Management Pathway

Otology
Rhinology
Head and Neck
Facial Plastics
Paediatrics

Multidisciplinary Patient Management



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ENT Conditions Treated

Essentially most ENT conditions

Except:

Tonsillectomy < 3 years

Adenoidectomy < 2 years

Paediatric airways <1-2 years e.g. stridor

ENT Presentation Running Order

- Ms Phoebe Roche – Thyroid and Parathyroid disease
- Ms Natalija Snovak – Hoarseness and Tonsils
- Mr Shawkat Abdulrahman – Sinus Disease and Rhinoplasty
- Prof Robbie Woods – Globus and Neck Lumps
- Q&A Session

Surgical Consideration of Thyroid and Parathyroid Disease

Phoebe Roche
Consultant Head & Neck and Thyroid Surgeon

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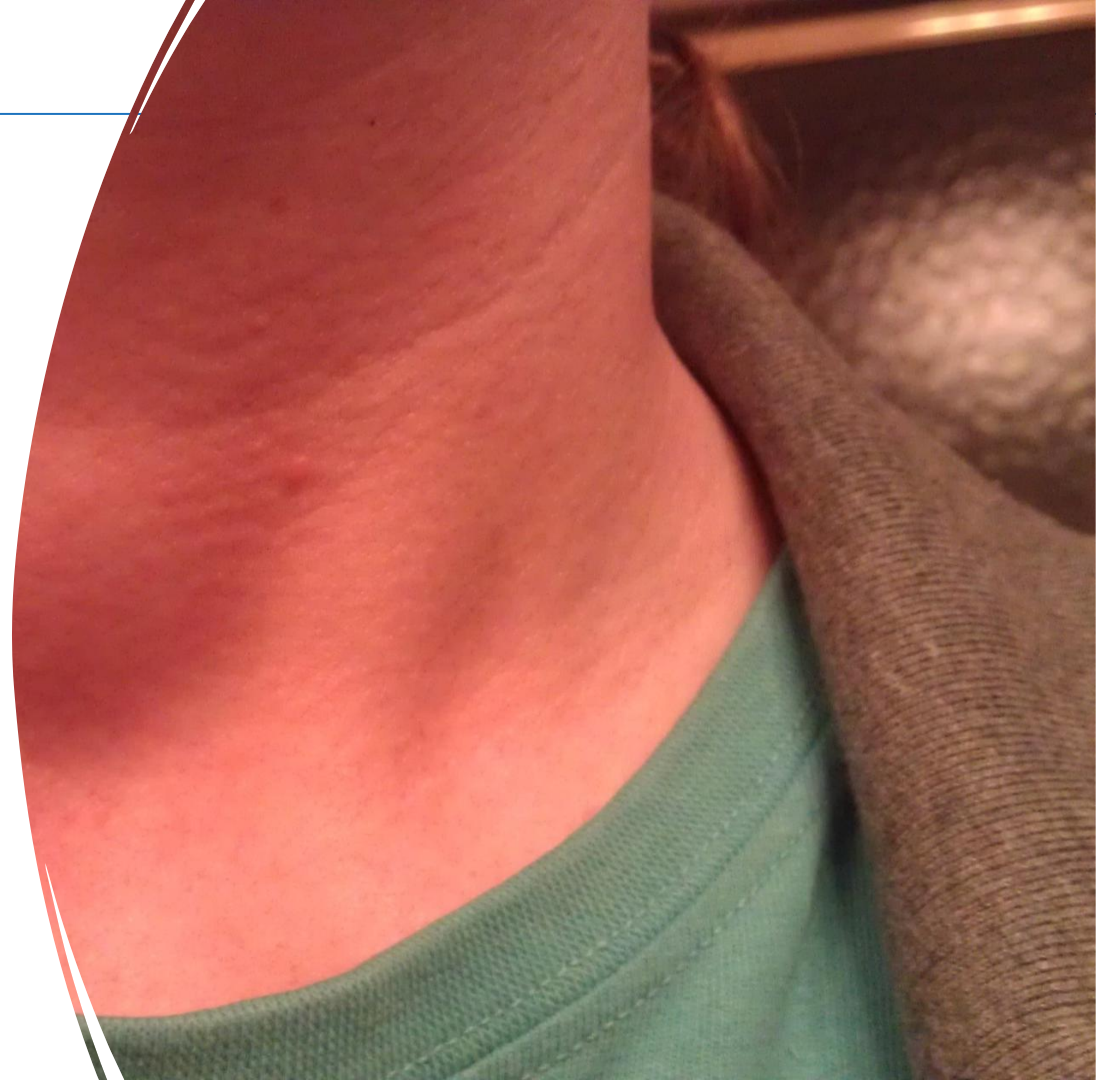
Thyroid Nodules

- Thyroid nodules are common
- Incidence of palpable nodules in women/men 5/1%
- Ultrasound raises this to 50-70%
- Thyroid cancer rare, incidence in the UK of approximately 7 per 100 000 women and 3 per 100 000 men
- 1 per cent of all malignancies



Who to refer and when

- **Patients with thyroid nodules who may be managed in primary care**
- Patients with a history of a nodule or goitre which has not changed for several years and who have no other worrying features (i.e. adult patient, no history of neck irradiation, no family history of thyroid cancer, no palpable cervical lymphadenopathy, no stridor or voice change).
- Patients with a non-palpable asymptomatic nodule <1 cm in diameter discovered incidentally on neck ultrasound(US) USS / CT /MRI without other worrying features.
- **Patients who should be referred non-urgently**
- Patients with nodules who have abnormal thyroid function tests (TFTs).These patients should be referred to an endocrinologist; thyroid canceris very rare in this group.
- Patients with a history of sudden onset of pain in a thyroid lump (likelyto have bled into a benign thyroid cyst).
- **Symptoms needing urgent referral**
- Unexplained hoarseness or voice changes associated with a goitre
- Thyroid nodule in a child
- Cervical lymphadenopathy associated with a thyroid mass(usually deepcervical or supraclavicular region)
- A rapidly enlarging, painless, thyroid mass over a period of weeks (a rarepresentation of thyroid cancer and usually associated with anaplastic thyroid cancer or thyroid lymphoma)

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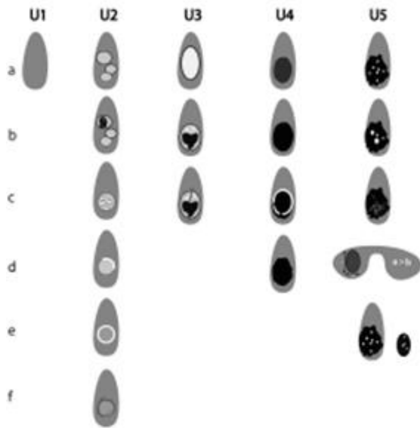
Ultrasound Assessment (U1-U5)



U1. Normal.

U2. Benign:
(a) halo, hyper- / iso-echoic
(b) cystic change +/- ring down sign (colloid)
(c) micro- cystic / spongiform
(d & e) peripheral egg shell calcification
(f) peripheral vascularity.

U3. Indeterminate/Equivocal:
(a) homogenous, hyper - echoic (markedly), solid, halo (follicular lesion).
(b) ? hypo-echoic, equivocal echogenic foci, cystic change
(c) mixed/central vascularity.

U4. Suspicious:
(a) solid, hypo-echoic (cf thyroid)
(b) solid, very hypo-echoic (cf strap muscle)
(c) disrupted peripheral calcification, hypo-echoic
(d) lobulated outline

U5. Malignant
(a) solid, hypo-echoic, lobulated / irregular outline, micro-calcification. (? Papillary carcinoma)
(b) solid, hypo-echoic, lobulated/irregular outline, globular calcification (? Medullary carcinoma)
(c) intra-nodular vascularity
(d) shape (taller >wide)
(e) characteristic associated lymphadenopathy

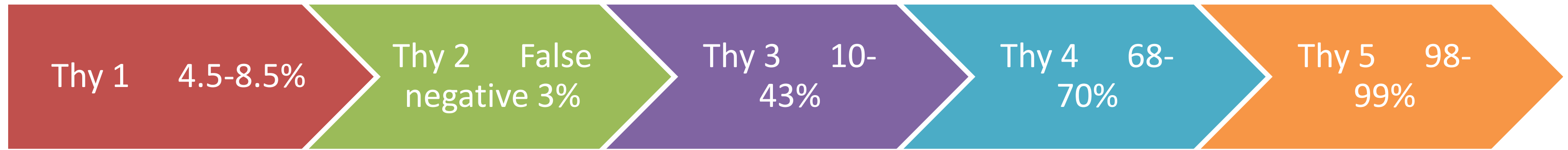
duced from BTA guidelines. Perros et al *Clinical endocrinology*, 2014 81 Suppl 1:1-12

Thy

Thy 1	Non-Diagnostic for cytological diagnosis
Thy1c	Non-Diagnostic for cytological diagnosis Cystic Lesion
Thy 2	Non - Neoplastic
Thy 2c	Non – Neoplastic Cystic Lesion
Thy 3a	Neoplasm Possible Atypia/Non-diagnostic
Thy 3f	Neoplasm Possible Suggesting follicular neoplasm
Thy 4	Suspicious of malignancy
Thy 5	Malignant

The Royal College of Pathologists
Pathology: the science behind the cure

Risk of malignancy

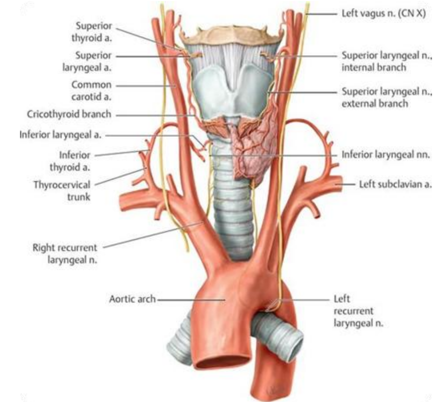


Thyroid Cancer

Papillary carcinoma 65%
Follicular carcinoma 20%
Medullary carcinoma 10%
Anaplastic carcinoma 5%

} Differentiated thyroid cancer

Lymphoma
Metastases



Diagnostic

For patients with Thy3 fine-needle aspiration cytology (FNAC)who require diagnostic surgery hemithyroidectomy is appropriate.

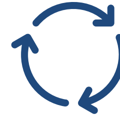
For patients with Thy4 FNAC, from a small, well defined target lesion suspicious of papillary(or medullary thyroid) cancer a diagnostic hemithyroidectomy/lymph node biopsy and positive intra-operative frozen section facilitates single stage therapeutic surgery.

Frozen section is not appropriate for follicular lesions.

Thyroid Cancer

Long-term prognosis for differentiated thyroid cancer (DTC) is excellent, with survival rates for adults being 92–98% at 10-year follow-up

5–20% of patients develop local or regional recurrence requiring further treatment

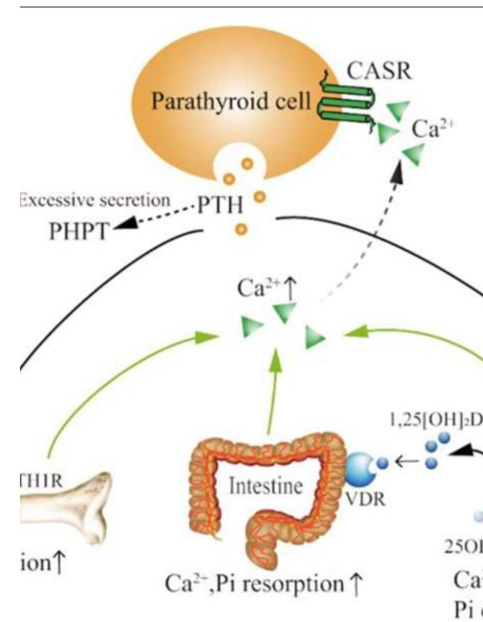


10–15% go on to develop distant metastases

Factors influencing prognosis include gender, age at presentation, histology and tumour stage

Parathyroid disease

- Primary HPT
- Hypercalcemia driven by excess parathyroid hormone (PTH) secretion
- Secondary HPT
- Deficiency of vitamin D in the blood causing the parathyroid glands to produce more than normal amounts of PTH
- Tertiary HPT
- Follows prolonged secondary hyperparathyroidism, when the parathyroid glands autonomously overproduce PTH in the absence of ongoing hypocalcaemia



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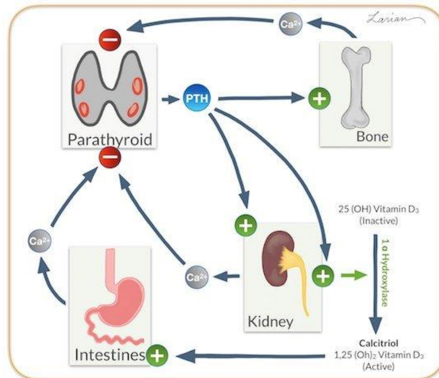
Primary hyperparathyroidism

- The most common cause of PHPTH is a single hyper-functioning parathyroid adenoma which accounts for 85-90% of cases. The remaining cases are caused by multiple parathyroid gland hyperplasia or multiple parathyroid adenomas.
- Parathyroid carcinoma is a rare cause of PHPTH
- HPTH is predominately a sporadic disease
- Approximately 10% of cases are familial and a hereditary predisposition should be considered in patients presenting with HPTH at a young age (<40 years), patients with clinical features of an endocrine neoplasia syndrome (e.g. pancreatic neuroendocrine tumours, pituitary adenoma) or patients with a family history of HPTH or endocrine tumours
- Patients with familial HPTH present most often with parathyroid hyperplasia or multiple parathyroid adenomas.

Assessment



Patient symptoms

- Generalised body aches with muscle weakness and fatigue
- Excessive thirst
- Low mood with or without depressive symptoms
- Frequent micturition with dehydration
- Altered bowel habit with a tendency towards constipation
- Calcinosis leading to renal stones
- Fractures - unexplained (usually secondary to osteoporosis)

Confirming biochemical diagnosis

End organ damage

Radiological localisation

Biochemical Diagnosis

PHPTH is defined biochemically as an elevated calcium level in the presence of an elevated or inappropriately normal parathyroid hormone level

Calcium corrected for albumin, intact PTH, a 25-hydroxyvitamin D level, serum alkaline phosphatase, serum urea and creatinine levels and serum phosphate

Treatment

1.3 Referral for surgery

- 1.3.1 Refer people with a confirmed diagnosis of primary hyperparathyroidism to a surgeon with expertise in parathyroid surgery if they have: symptoms of hypercalcaemia such as thirst, frequent or excessive urination, or constipation **or** end-organ disease (renal stones, fragility fractures or osteoporosis) **or** an albumin-adjusted serum calcium level of 2.85 mmol/litre or above.
- 1.3.2 Consider referral to a surgeon with expertise in parathyroid surgery for people with a confirmed diagnosis of primary hyperparathyroidism even if they do not have the features listed in recommendation 1.3.1.
- Medical management - calcimimetic such as Cinacalcet

Surgery

Focused parathyroidectomy

➢Localised adenoma on imaging

Unilateral exploration

➢Doubt on imaging

Bilateral exploration

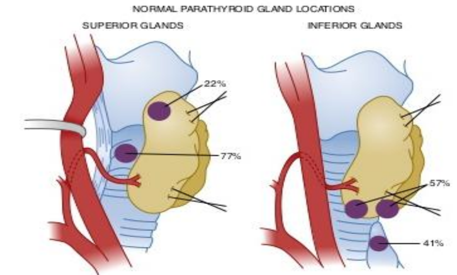
➢Negative imaging

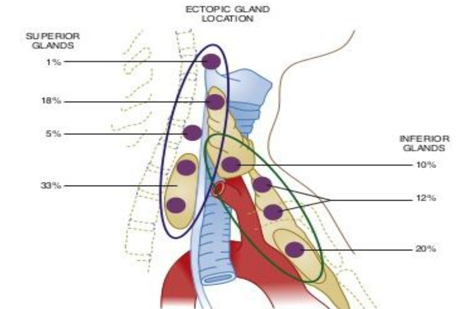
➢Discordant imaging

➢MEN/hyperplasia/lithium/tertiary HPT

➢Negative focused approach

➢3/3.5 gland excision ? Reimplantation





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MANAGEMENT OF PATIENTS WITH DYSPHONIA AND REMINDER ON TONSILLECTOMY INDICATIONS

Natalija Snovak, Consultant ENT Surgeon

18/04/2026

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DYSPHONIA: KEY MESSAGES

Clinical Practice Guideline: Hoarseness (Dysphonia) (Update)
Stachler, R. J., Francis, D. O., et al. (2018).
Otolaryngology—Head and Neck Surgery, 158(1_Suppl), S1-S42.

1. **Dysphonia,** also known as hoarseness, is a general term used to describe a **variety of changes in voice quality**
2. Clinicians should perform **laryngoscopy**, or refer to a clinician who can perform laryngoscopy, when dysphonia fails to resolve or improve **within 4 weeks** or **irrespective of duration if a serious underlying cause is suspected**
3. **Before voice treatment** is prescribed, clinicians should perform **diagnostic laryngoscopy**, or refer to a clinician who can perform diagnostic laryngoscopy
4. Clinicians should **advocate for voice therapy** for patients with dysphonia from a **cause amenable to voice therapy- SLT**

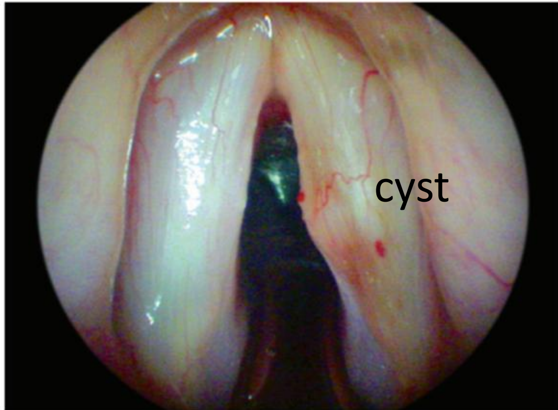
Factors where **EXPEDITED** laryngeal evaluation is indicated, but not limited to:

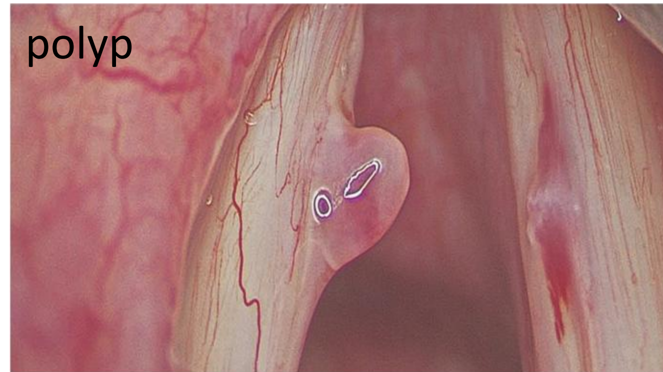
- recent surgical procedures involving the head, neck or chest
- recent endotracheal intubation
- presence of concomitant neck mass
- respiratory distress or stridor
- history of tobacco abuse
- whether the patient is a professional voice user
- recent neck trauma
- referred otalgia +/- unilateral throat discomfort/pain

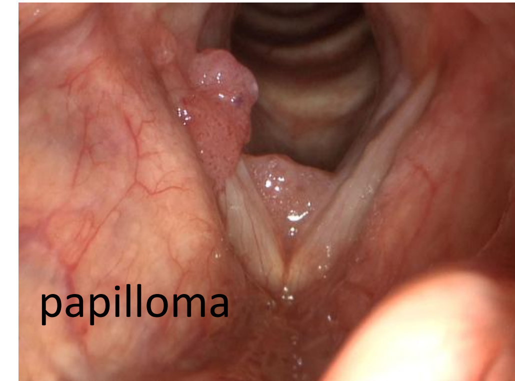
DYSPHONIA: COMMON CAUSES

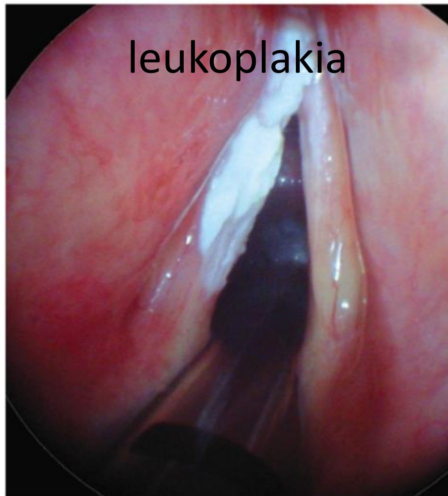
- **Acute laryngitis** – short duration, <4 weeks, viral, no need for laryngoscopy
- **Laryngopharyngeal reflux**- if clear history of reflux you can start PPIs for a month and Gaviscon Advance 10 ml QDS, reassess and refer if no improvement
- **Voice misuse** – does require laryngoscopy, ideally assessment in voice clinic with ENT and SLT
- **Benign lesions** – pictures on the next slide, ENT surgery required +/- SLT
- **Presbyphonia** – aging related changes, referral to SLT reasonable
- **Malignancy rare** but critical

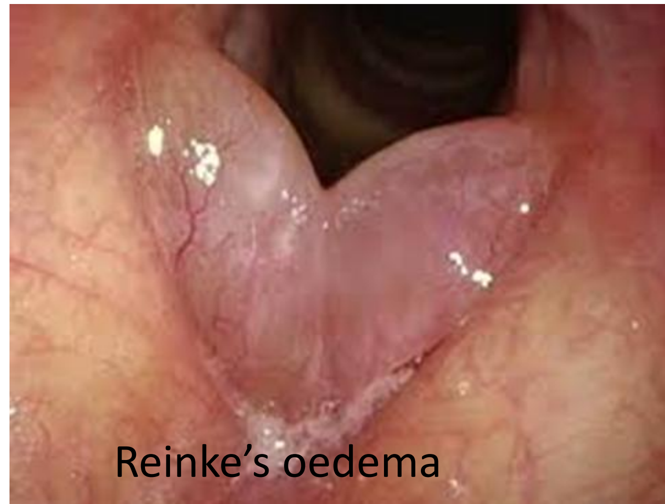
BENIGN VOCAL CORD LESIONS for SURGICAL MANAGEMENT











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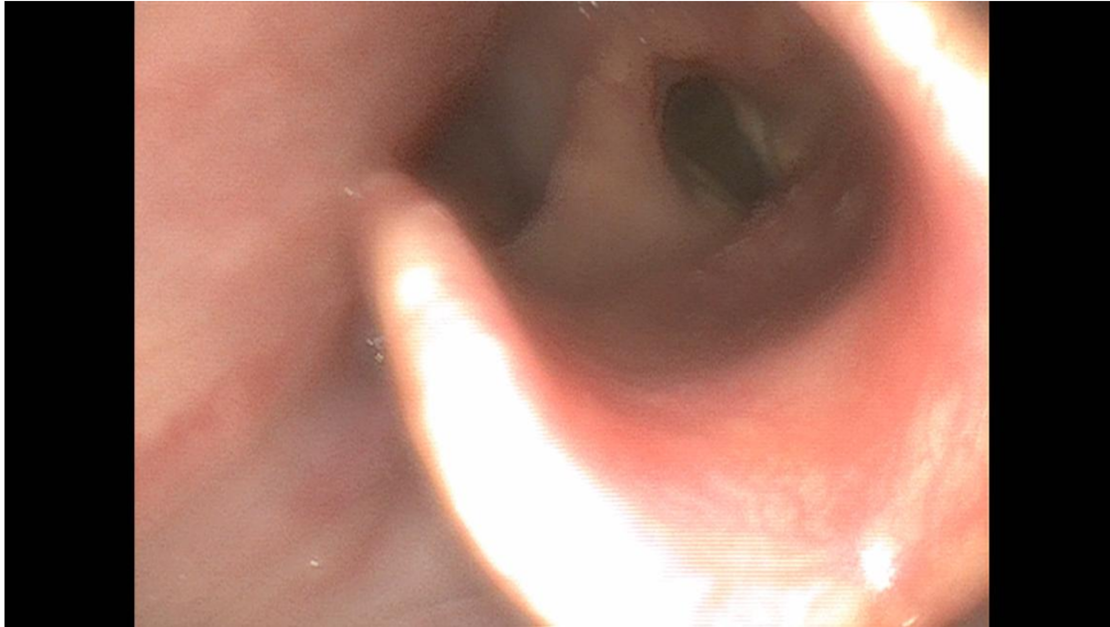
PATIENT WITH PRESBYPHONIA- AGING VOICE LARYNGOSCOPY AND STROBOSCOPY



72 yo male
Persistent hoarse voice for >1 year, can't sing anymore

Laryngoscopy/ Stroboscopy:
Vocal cord atrophy
Secondary muscle tension
Small cyst under left vocal cord

Treatment:
MLB +injection augmentation -**ENT**
voice therapy - **SLT**
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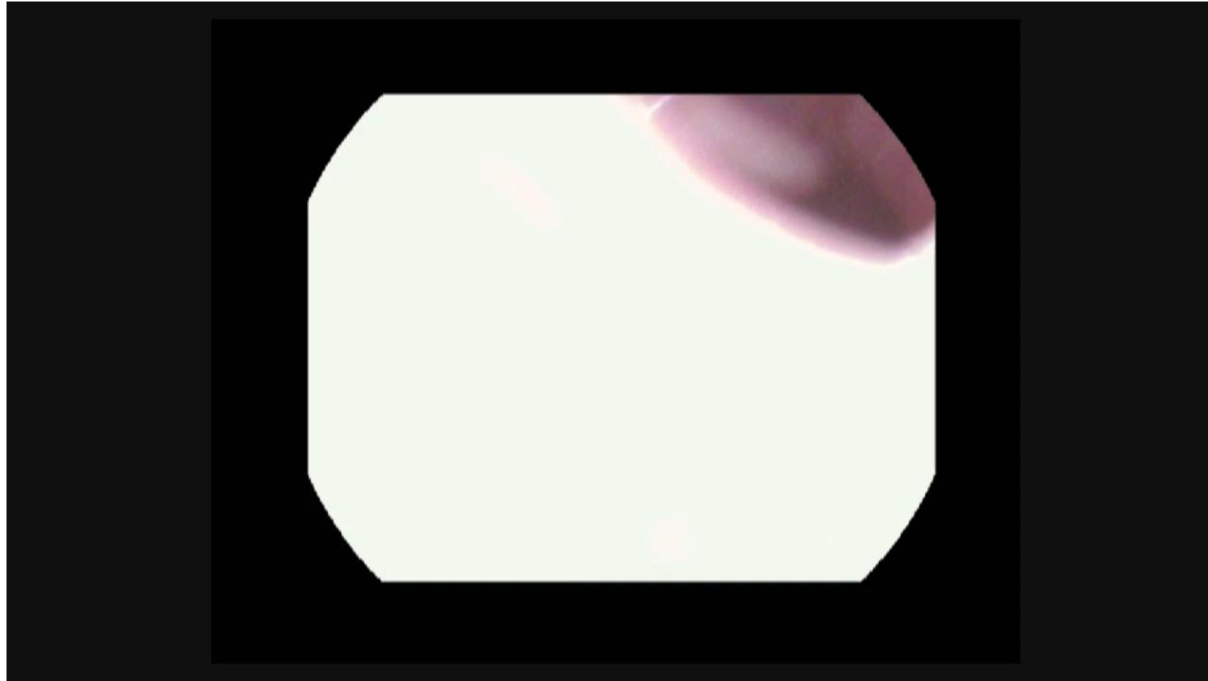
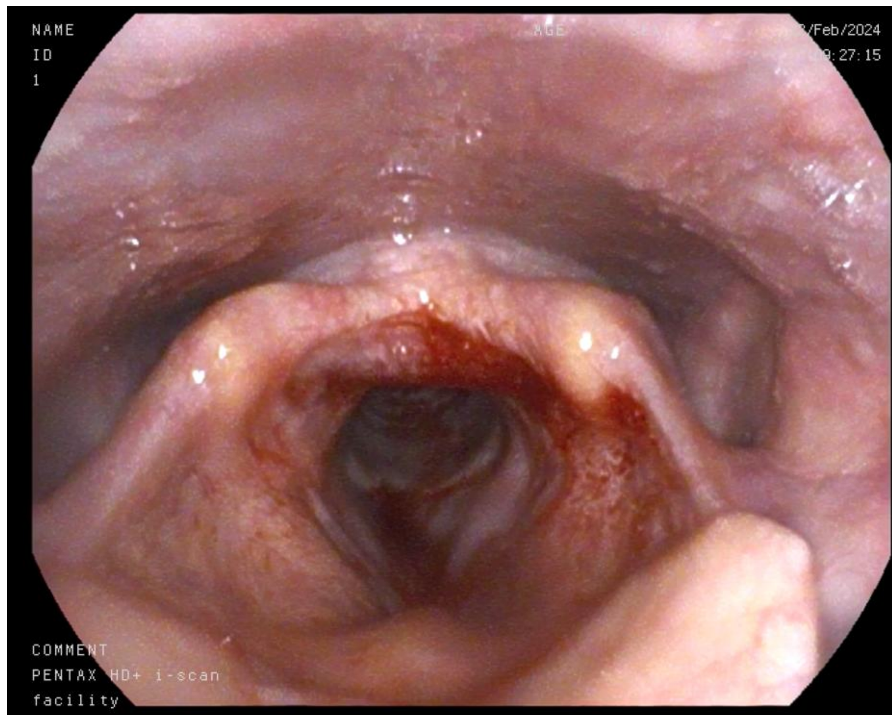
PATIENT WITH LEFT VOCAL CORD PALSY



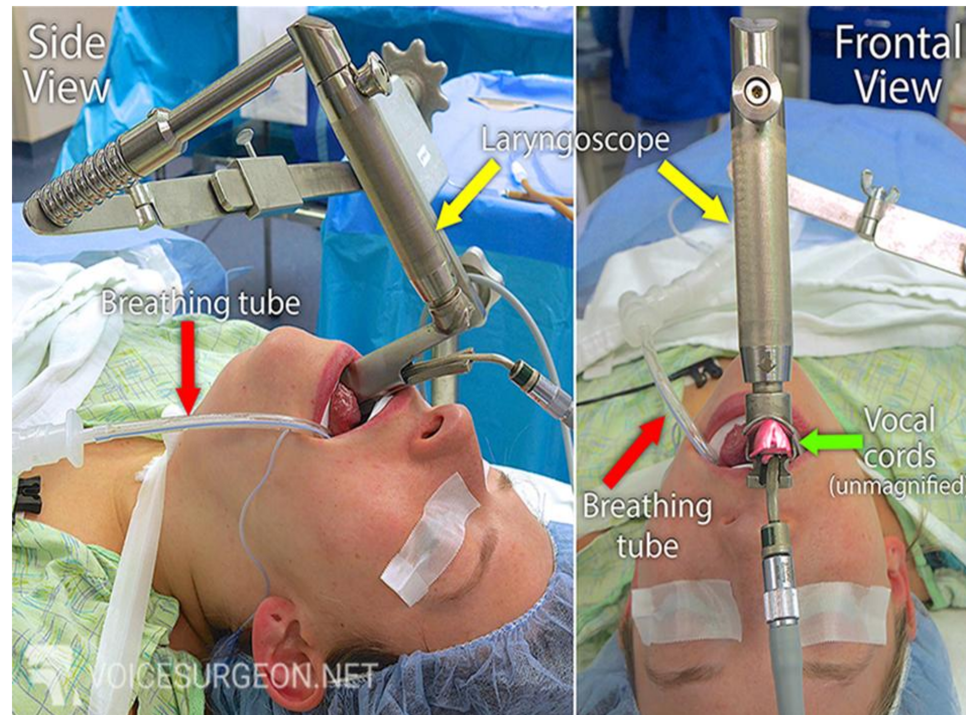
54 yo male
Thyroid surgery 1 year ago and left vocal cord palsy
Voice fatigue, affects his everyday work as a teacher
Laryngoscopy/ Stroboscopy:
Left vocal cord palsy, MTD
Treatment:
Injection augmentation + recurrent laryngeal nerve reinnervation -**ENT**
voice therapy - **SLT**
} Team

TREATMENT OPTIONS

INJECTION AUGMENTATION VOCAL CORDS



MICROLARYNGOSCOPY



DYSPHONIA: Questions I want you to leave with answers to:

- When should I refer hoarseness?
- Who needs urgent referral?
- What should I never miss?

CONCLUSION:

- The biggest mistake is not missing the rare disease- it’s normalising persistent symptoms.
- If the voice is still hoarse after 3-4 weeks, and you don’t know why – refer patient to ENT for laryngoscopy.

TONSILLECTOMY INDICATIONS - Most sore throats do NOT need

1. *SIGN (April 2010). Management of sore throat and indications for tonsillectomy*

- **7 or more** well documented, clinically significant, adequately treated sore throats in the preceding year
- **5 or more** such episodes in each of the preceding two years
- **3 or more** such episodes in each of the preceding three years

Group A Strep: Centor criteria (fever, tonsillar exudate, tender lymph nodes, absence of cough)

- AND episodes of sore throat are disabling preventing normal function
- OR immunocompromised or have other medical conditions (e.g. diabetes, cystic fibrosis)

- Obstructive sleep apnoea (OSA)
- Malignancy or suspected malignancy
- Recurrent peritonsillar abscess (after 2nd episode)

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www.TheEarNoseThroatDoctor.com

Nose inside /Out

Mr Shawkat Abdulrahman
OtoRhinoLaryngology ,
Rhinology and Endoscopic Skull Base Surgeon
FACS,FRCSI

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Mr Shawkat Abdulrahman
The Ear Nose Throat Doctor

Beacon Hospital
Tallaght University Hospital

NO DISCLOSURE

www.TheEarNoseThroatDoctor.com

AR

CRS

Rhinoplasty

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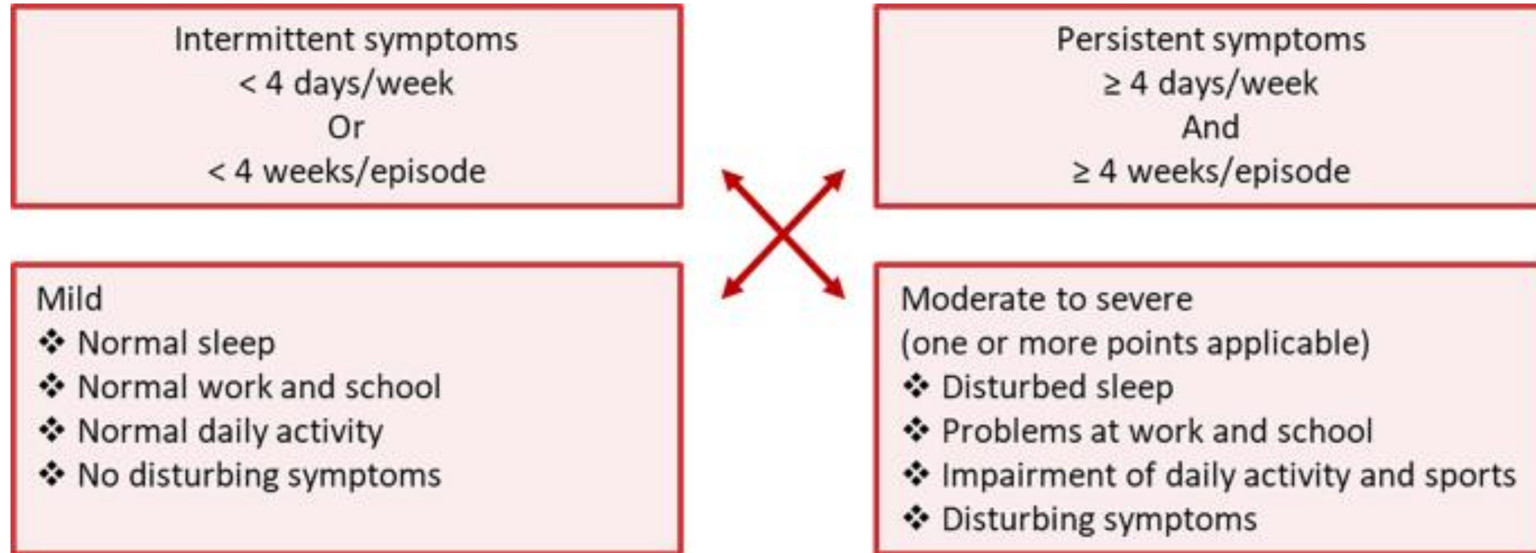
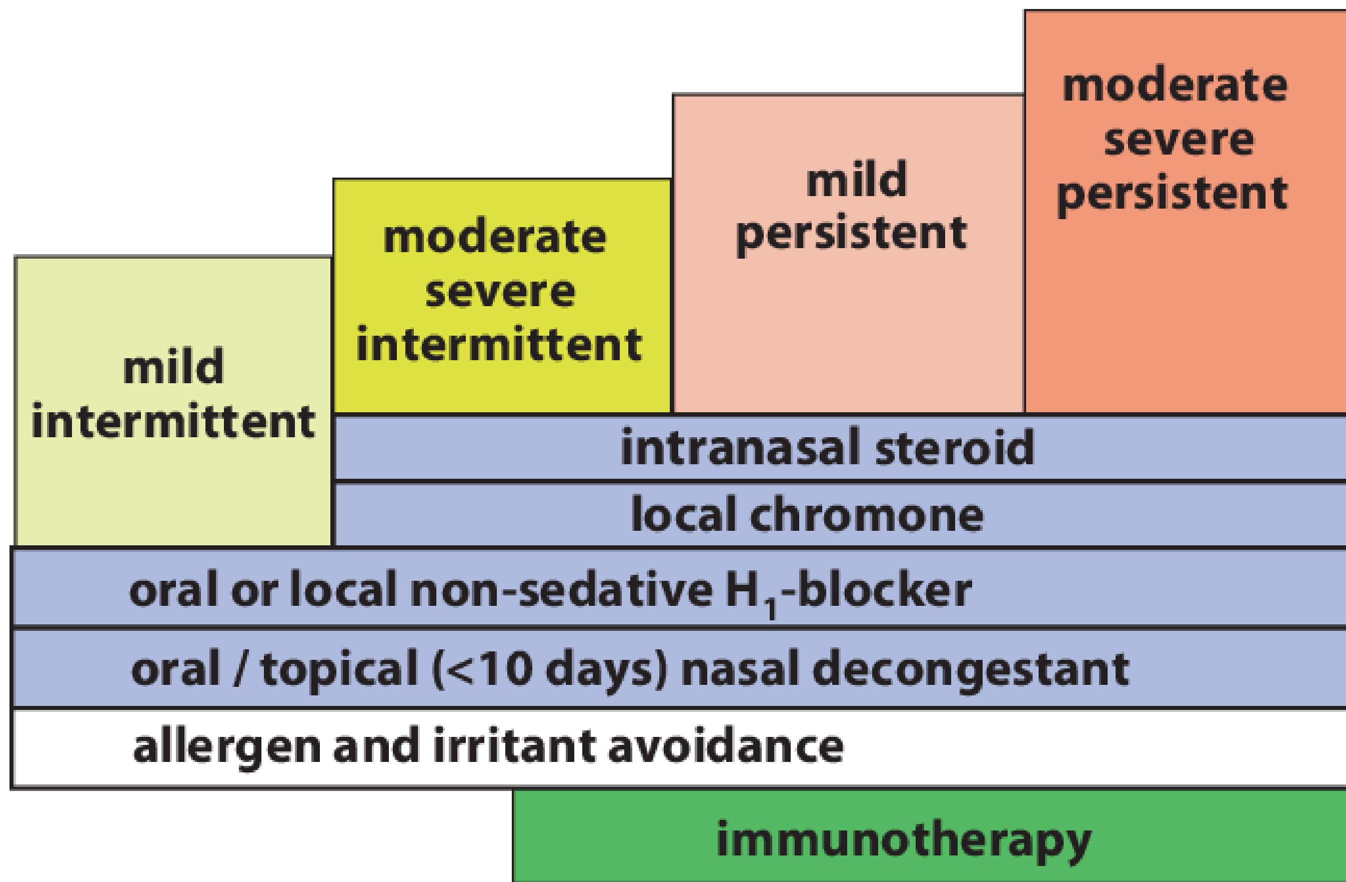
AR

• New classification of rhinitis

The classification of AR was revised by ARIA in 2001.A major change was the introduction of the terms "**intermittent**" and "**persistent**".

Before then, AR was classified, based on the **time** and **type of exposure** and **symptoms**





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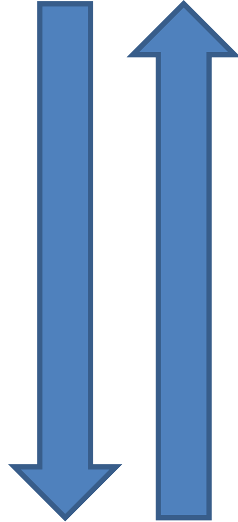
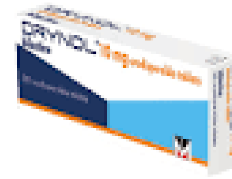


1. **Antihistamine** Syrup/Tablet



2. **CS/Antihistamine combined spray** age restriction

3. **Anti Montelucast** tab ……!nightmare
4. **Immunotherapy** with allergy test
5. **Surgery** for turbinoplasty

Better to have CT sinus GP Scheme!

1. What scan types are included in the GP Access to Community Diagnostics Scheme?

MRI		CT	
MRI Brain	MRI Thoracic Spine to include thoracolumbar	CT Brain	CT Neck
MRI IAMs	MRI Hip	CT Sinus	CT Neck & Thorax
MRI Brain & IAM's	MRI Knee	CT KUB/Renal	CT Brain & Sinus
MRI Pituitary Contrast	MRI Shoulder	CT Thorax	CT Lumbar Spine
MRI Lumbar Spine	MRI Bony *Pelvis	CT Abdomen & Pelvis	CT Cervical Spine
MRI Lumbosacral Spine	MRI *Pelvis and Hips	CT Abdomen (Liver, Pancreas)	CT Thorax HRCT
MRI SIJ's	MRI Cervical Spine to include cervicothoracic	CT Thorax & Abdomen	
*Excludes MRI Pelvis Gynae			

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AR

CRS

Rhinoplasty

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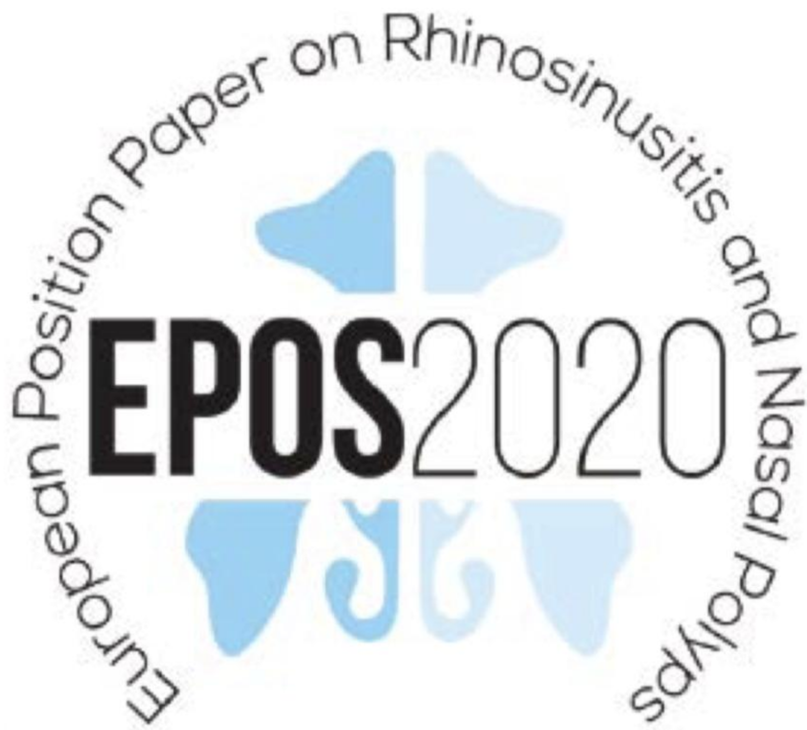

CRS

2003 → 2007 → 2012 → 2020

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ARS divided into :

- viral ARS (common cold),
- post-viral ARS and ABRS (acute bacterial rhinosinusitis)

Common cold

Acute viral rhinosinusitis: duration of symptoms <10 days

Acute post-viral

Increase in symptoms >5 days or persistent symptoms >10 days with <12 weeks duration

Acute bacterial

Defined by at least three symptoms / signs:

- discoloured mucus;
- severe local pain;
- fever >38°C;
- raised CRP/ESR;
- 'double' sickening.

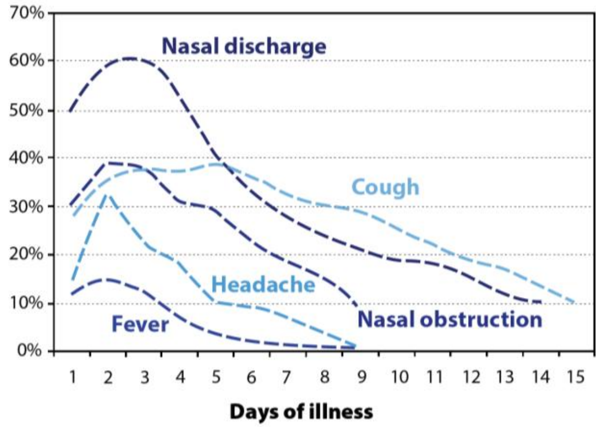
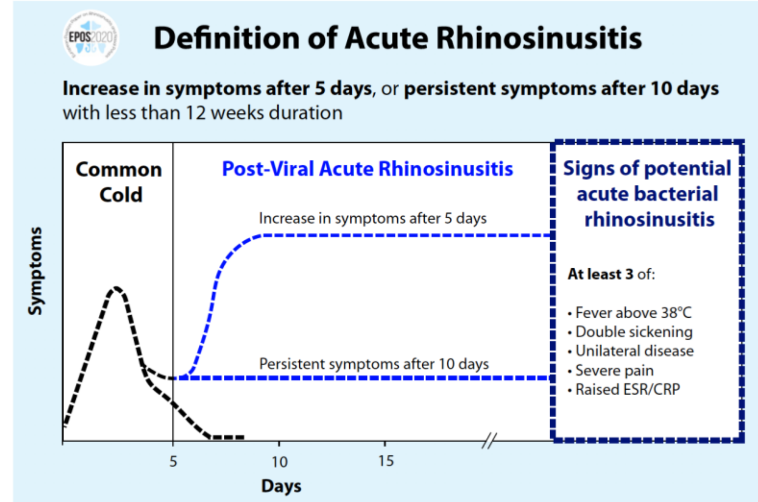


Figure 2.3.1. Definition of acute rhinosinusitis.



It is clear that most symptoms, however, resolve by day 5 and that in general it is **impossible to differentiate between bacterial and non-bacterial before this time**, although the possibility of bacterial infection increases if there is deterioration in symptoms after day 5.

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Figure 1.4.1. Integrated care pathway of acute rhinosinusitis.

EPOS 2020: Care pathways for acute rhinosinusitis (ARS)

Self-Care Pharmacy

Two **ARS** symptoms
One of which should be **nasal obstruction** and/or **discoloured discharge**

± facial pain/pressure
± reduction or loss of smell
<10 days

→ Check for likely **ABRS**
≥ 3 of the following:
- Fever above 38°C
- Double sickening
- Unilateral disease
- Severe pain
- Raised ESR/CRP

⊖ → **Self-Care**
- Self-education / e-Health
- Decongestants <10 days
- NSAIDs / paracetamol
- Herbal medicine
- Zinc
- Vitamin C
- Consider saline spray / rinses
- **Avoid antibiotics**

⊕ → Refer to / Treatment by **Primary Care**

Primary Care

Check for likely **ABRS**
≥ 3 of the following:
- Fever above 38°C
- Double sickening
- Unilateral disease
- Severe pain
- Raised ESR/CRP

⊖ → **Symptoms >10 days** or **increased after 5 days?**
⊖ → Self-Care
⊕ → **Appropriate therapy**
- INCS
- Decongestants <10 days
- Herbal medicine
- Saline spray / rinses
- **Avoid antibiotics**

⊕ → **≥3 episodes of ABRS** last year?
⊖ → Consider **antibiotics**
No other investigations
→ Improvement **after 10 days** of antibiotics?
⊖ → Refer to Secondary / Tertiary Care

⊕ → Refer to **Secondary / Tertiary Care**

Secondary / Tertiary Care

Consider and test for differential diagnosis and treat accordingly
(e.g., odontogenic, fungal ball, bacterial resistance, immunodeficiency)

or non-sinus diagnoses
(e.g., migraine)

PRESENCE OF ALARM SYMPTOMS

• Periorbital oedema/erythema	• Severe headache
• Displaced globe	• Frontal swelling
• Double vision	• Signs of sepsis
• Ophthalmoplegia	• Signs of meningitis
• Reduced visual acuity	• Neurological signs

IMMEDIATE REFERRAL

ABRS, acute bacterial rhinosinusitis; INCS, intranasal corticosteroids.

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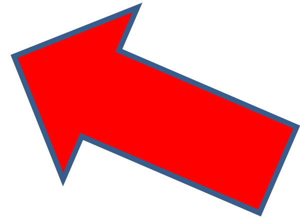
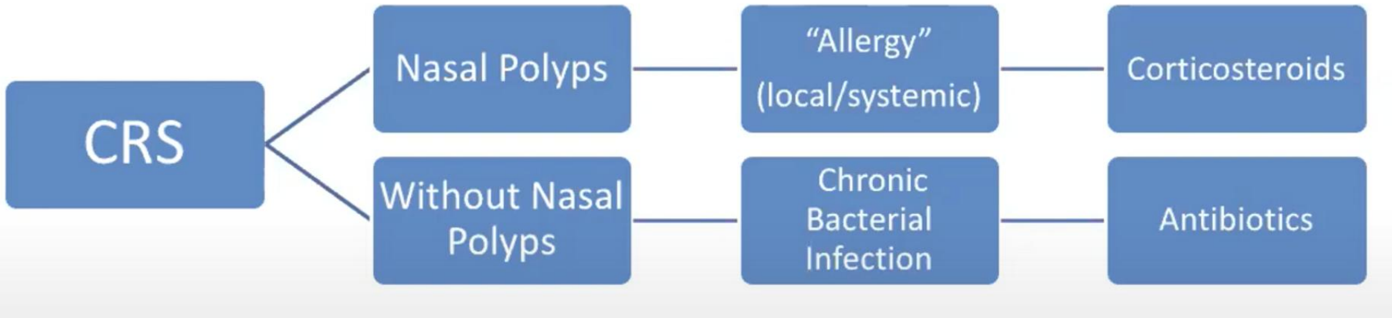
PRESENCE OF ALARM SYMPTOMS

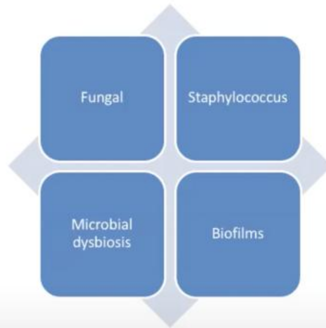
- Periorbital oedema/erythema
- Displaced globe
- Double vision
- Ophthalmoplegia
- Reduced visual acuity
- Severe headache
- Frontal swelling
- Signs of sepsis
- Signs of meningitis
- Neurological signs

IMMEDIATE REFERRAL



Old presumptions





Targeted therapies against these hypothetical etiologies have been unsuccessful

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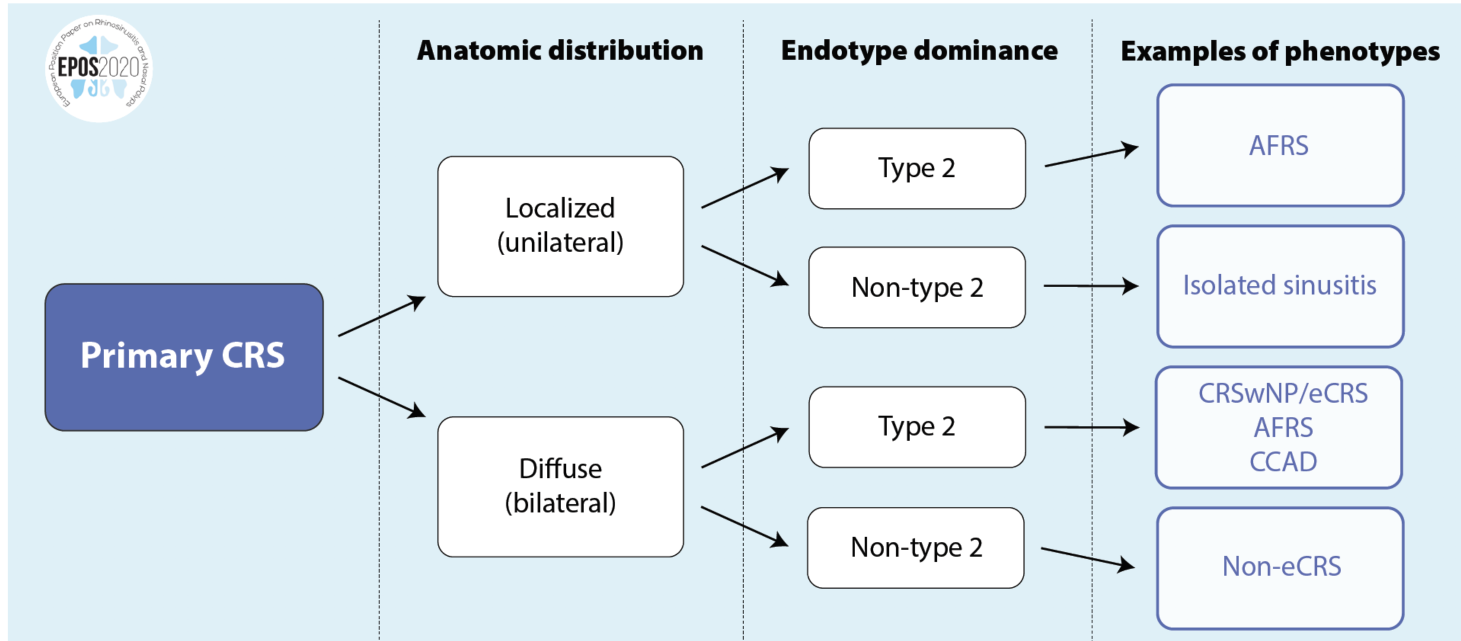
Figure 1.2.1. Classification of primary CRS (Adapted from Grayson et al[154])



AFRS, allergic fungal rhinosinusitis; CCAD, central compartment allergic disease; CRSwNP, chronic rhinosinusitis with nasal polyps; eCRS, eosinophilic CRS.

eCRS? eCRS v non-eCRS : 10/hpf (400x) eosinophils or higher on histology

CCAD? variant of CRS with polypoid changes of the entire central sinonasal compartment while the lateral sinus mucosa remains relatively normal (‘black halo’), likely due to allergy

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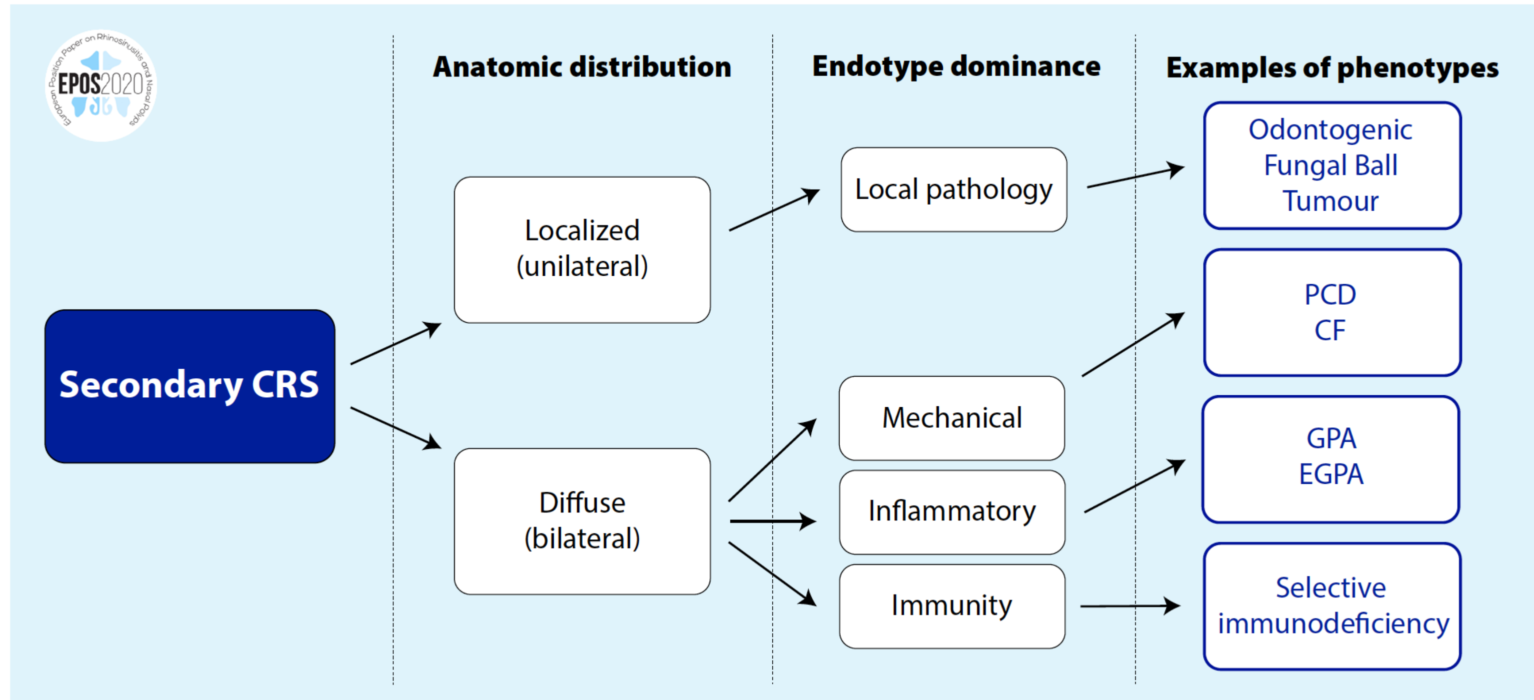
Figure 1.2.2. Classification of secondary CRS (Adapted from Grayson et al[154]).



CF, cystic fibrosis; EGPA, eosinophilic granulomatosis with polyangiitis (Churg-Strauss disease); GPA, granulomatosis with polyangiitis (Wegener's disease); PCD, primary ciliary dyskinesia.

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CS

INCS

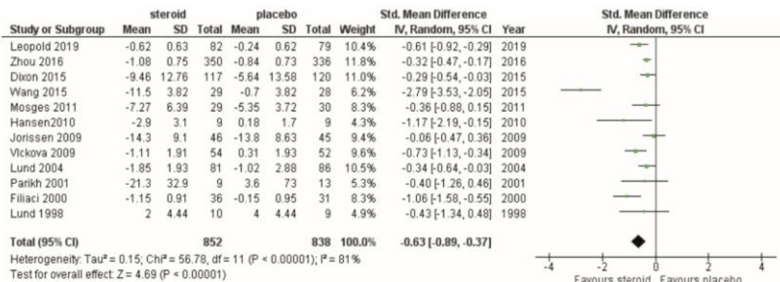


Figure 6.1.5.2. Forest plot of the effect of nasal corticosteroids versus placebo on change in symptom score in patients with CRS compared to placebo.with CRS.

Study or Subgroup	steroid Mean	steroid SD	steroid Total	placebo Mean	placebo SD	placebo Total	Weight	Std. Mean Difference IV, Random, 95% CI	Year
Leopold 2019	-0.62	0.63	82	-0.24	0.62	79	10.4%	-0.61 [-0.92, -0.29]	2019
Zhou 2016	-1.08	0.75	350	-0.84	0.73	336	11.8%	-0.32 [-0.47, -0.17]	2016
Dixon 2015	-9.46	12.76	117	-5.64	13.58	120	11.0%	-0.29 [-0.54, -0.03]	2015
Wang 2015	-11.5	3.82	29	-0.7	3.82	28	6.2%	-2.79 [-3.53, -2.05]	2015
Mosges 2011	-7.27	6.39	29	-5.35	3.72	30	8.3%	-0.36 [-0.88, 0.15]	2011
Hansen2010	-2.9	3.1	9	0.18	1.7	9	4.3%	-1.17 [-2.19, -0.15]	2010
Jorissen 2009	-14.3	9.1	46	-13.8	8.63	45	9.4%	-0.06 [-0.47, 0.36]	2009
Vlckova 2009	-1.11	1.91	54	0.31	1.93	52	9.6%	-0.73 [-1.13, -0.34]	2009
Lund 2004	-1.85	1.93	81	-1.02	2.88	86	10.5%	-0.34 [-0.64, -0.03]	2004
Parikh 2001	-21.3	32.9	9	3.6	73	13	5.3%	-0.40 [-1.26, 0.46]	2001
Filiaci 2000	-1.15	0.91	36	-0.15	0.95	31	8.3%	-1.06 [-1.58, -0.55]	2000
Lund 1998	2	4.44	10	4	4.44	9	4.9%	-0.43 [-1.34, 0.48]	1998
Total (95% CI)			**852**			**838**	**100.0%**	**-0.63 [-0.89, -0.37]**	

Heterogeneity: $Tau^2 = 0.15$; $Chi^2 = 56.78$, df = 11 ($P < 0.00001$); $I^2 = 81\%$
Test for overall effect: $Z = 4.69$ ($P < 0.00001$)

Short course systemic CS in CRSwNP

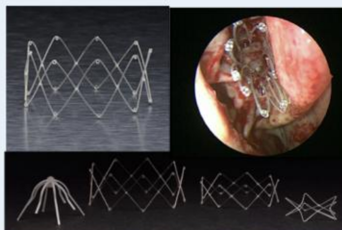
- Improvement overall 2-3 wks,
- **no sig diff at 10-12 wks** in syms in 50% pts despite NP score still sig reduced
- Some S/Es – gi tract, psychological

Eluting stents

Dexamethasone:Beule et al Am J Rhinol 2009

Mometasone: Propel, Advance, Resolve, Sinuva etc

Kern 2018, Han 2014



Sig improvement in symptoms, polyp size & need for surgery

INCS irrigation in post-op CRS

MMNS irrigation sig improved VAS, SNOT22, LM CT

BUD irrigation – no sig diff shown

- Adrenal function (1 study) – no effect

MMNS:mometasone. BUD:budesonide Respules

**Harvey et al IFAR 2018*

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EPOS2020

Medical treatment of CRS

Saline irrigation or rinsing

- Isotonic or Ringers lactate better than hypertonic
- Method of instillation, concentration, volume, pressure, frequency, temperature or head position?
- Recommended+/- surgery(1a/GradeA)but difficult to recommend one method over another

- Additions to enhance antisepsis and/or biofilm disruption
- Evidence for : xylitol, sodium hyaluronate, xyloglucan
- Insufficient evidence for : surfactant, baby shampoo, Manuka honey, dexpanthenol, hot water, hypertonic soln

Duration of antibiotic courses

- The EPOS panel agreed that 4weeks or less would be 'short-term', accepting that in general practice the duration is usually <10 days,
- and >4 weeks would be regarded as 'long-term'.

Macrolide duration in CRS

- 4.7% improvement at 2 weeks
- 71% improvement at 12 weeks[1]
- Needs 6-8 weeks to have sig impact
- Improvement at 3 months continues to 12 months[2,3]

1-Hashiba & Baba Acta Otolaryngol 1996
2-Cervin et al Otolaryngol Head Neck 2002
3-Ragab et al Laryngoscope 2004

Macrolide not equal

EPOS can NOT make recommendation

Placebo controlled RCTs with oral antibiotics in CRSwNP

Study	Drug	N=	Time/Dose	Effect symptoms	Level of Evidence
Schalek 2009	Anti staph antibiotic placebo controlled	23	3 Weeks	No significant effect at 3 and 6 months, endoscopy SNOT-22	1b (-)
Van Zele 2010	Doxycycline placebo controlled	47	3 weeks/100 mg day	Reduction of polyp size and postnasal secretion, reduction of pro-inflammatory markers	1b

Does not fulfil EPOS criteria of long-term

Biological option

Dupilumab (DPL) Efficacy in Patients With Severe Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) with/without Nonsteroidal Anti-inflammatory Drug-Exacerbated Respiratory Disease (NSAID-ERD): SINUS-24, SINUS-52 Trials

Joaquim Mullol, Tanya M. Laidlaw, Nikhil Amin, Claus Bachert, Joseph K. Han, Peter W. Hellings, G. Walter Canonica, Seong H. Cho, Jorge F. Maspero, Martin Desrosiers, Claire Hopkins, Pierluigi Paggiaro, Mei Zhang, Xin Lu, Naimish Patel, Neil M.H. Graham, Heribert Staudinger, Leda P. Mannent

European Respiratory Journal 2019 54: RCT3783; **DOI:** 10.1183/13993003.congress-2019.RCT3783

- Only FDA approved monoclonal antibody of CRSwNP
- Significant improvement in SNOT 22 & LMS
- Significant reduction to revision surgery 73%
- EPOS recommends its use if indicated

Anti- IL-5
- mepolizumab
- reslizumab.

Anti-IL-4/anti-IL-13
- **dupilumab**

Anti-IgE
- omalizumab

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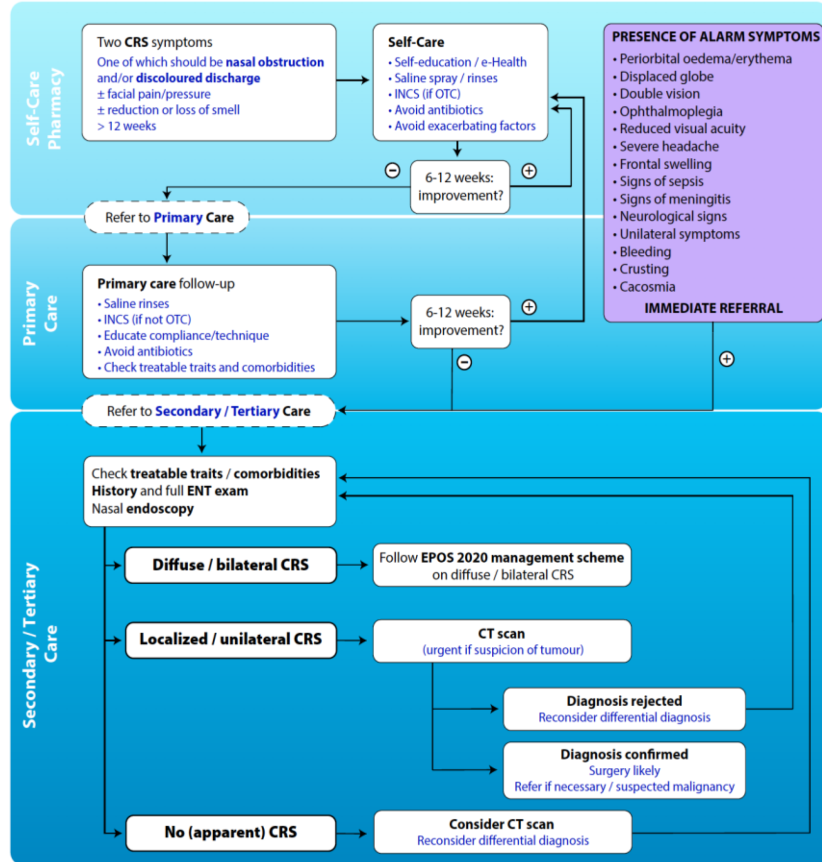
Figure 1.6.1. Treatment evidence and recommendations for adults with chronic rhinosinusitis.



CRS: chronic rhinosinusitis; CT, computed tomography; INCS, intranasal corticosteroids spray; OTC, over-the-counter.

GP Access to Community Diagnostics & GP Access to Community Ultrasound

Frequently Asked Questions

Last Updated: January 2025

1. What scan types are included in the GP Access to Community Diagnostics Scheme?

MRI		CT	
MRI Brain	MRI Thoracic Spine to include thoracolumbar	CT Brain	CT Neck
MRI IAMs	MRI Hip	CT Sinus	CT Neck & Thorax
MRI Brain & IAM's	MRI Knee	CT KUB/Renal	CT Brain & Sinus
MRI Pituitary Contrast	MRI Shoulder	CT Thorax	CT Lumbar Spine
MRI Lumbar Spine	MRI Bony *Pelvis	CT Abdomen & Pelvis	CT Cervical Spine
MRI Lumbosacral Spine	MRI *Pelvis and Hips	CT Abdomen (Liver, Pancreas)	CT Thorax HRCT
MRI SIJ's	MRI Cervical Spine to include cervicothoracic	CT Thorax & Abdomen	
*Excludes MRI Pelvis Gynae			

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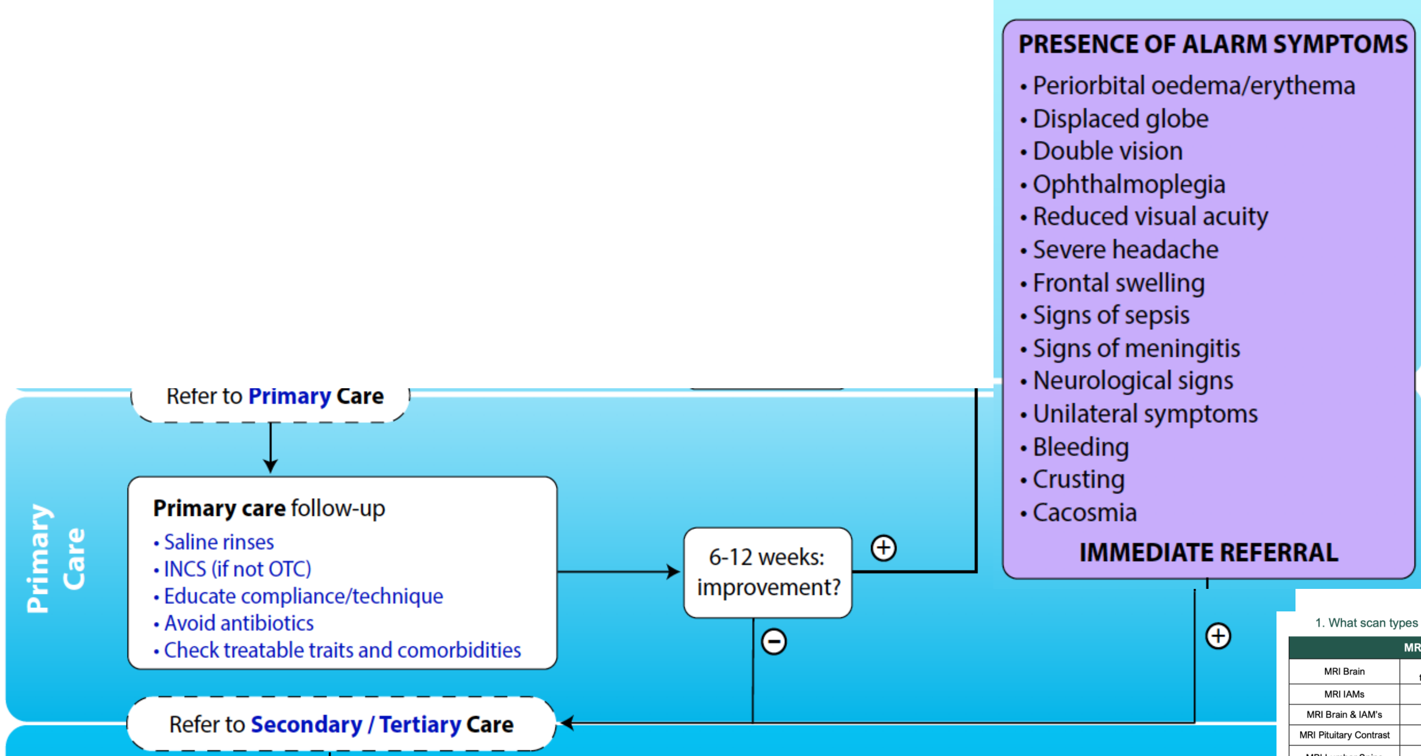

GP Access to Community Diagnostics & GP Access to Community Ultrasound

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MRI SIJ's	MRI Cervical Spine to include cervicothoracic	CT Thorax & Abdomen	
*Excludes MRI Pelvis Gynae			

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Conclusion

- **Nasal Saline Irrigations**: High-volume saline rinses (e.g., NeilMed squeeze bottle, neti pot) should be used at least twice daily to mechanically remove mucus, allergens, and inflammatory debris.
- **Topical Intranasal Corticosteroids (INCS)**: Daily use of nasal steroid sprays (e.g., fluticasone, mometasone) is critical to reduce inflammation.
- **Oral Corticosteroids**: Short-term (3-7 days) courses of systemic steroids (e.g., prednisone) may be used to reduce severe inflammation or shrink nasal polyps.
- **Antibiotics**: Used if there is evidence of an acute, superimposed bacterial infection. Long-term, low-dose macrolide antibiotics may be considered for non-polyp cases, though routine use is limited.
- **Biologic Agents**: For severe **CRSwNP** (chronic rhinosinusitis with nasal polyps) that is resistant to other therapies, biologics like dupilumab, omalizumab, or mepolizumab can reduce polyp size and improve quality of life.
- **Allergy Management**: Allergy testing and subsequent treatments (antihistamines, immunotherapy) can manage underlying allergies associate with CRS.
- **Adjunctive Therapies**: Antileukotriene agents may be added for patients with asthma or aspirin sensitivity.

AR

CRS

Rhinoplasty

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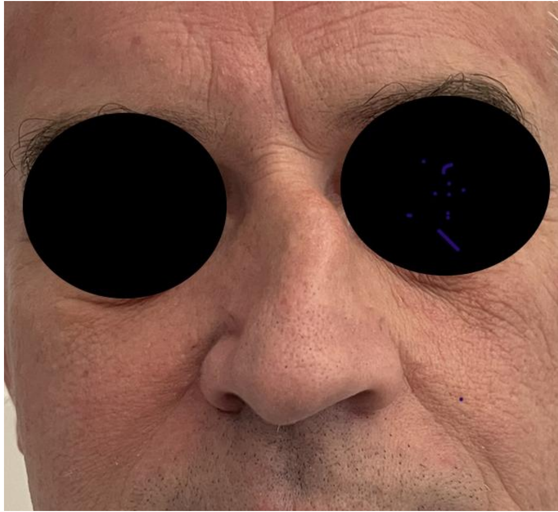
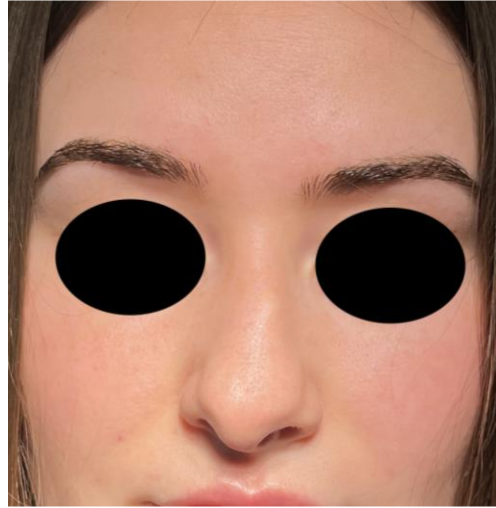
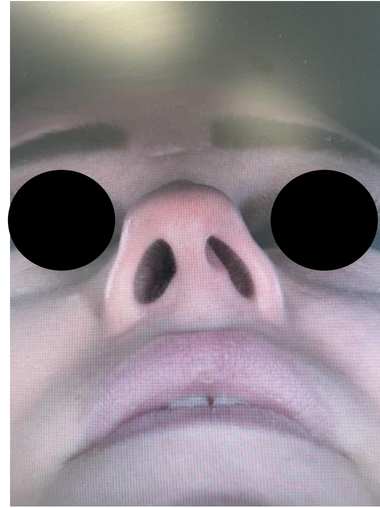
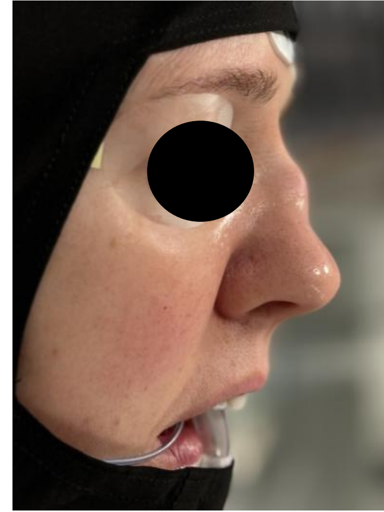
Rhinoplasty

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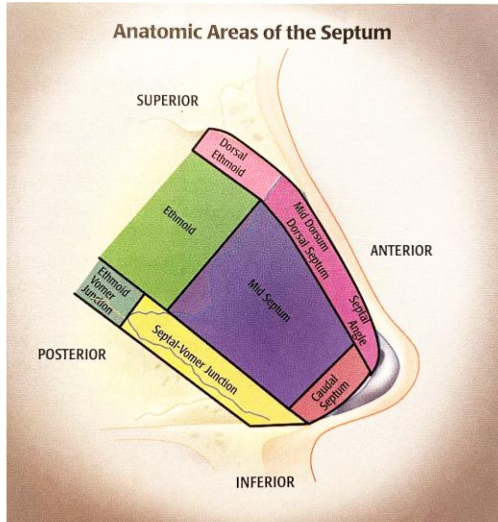
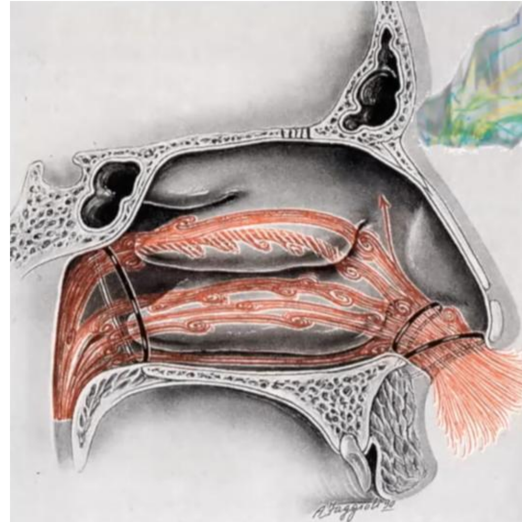
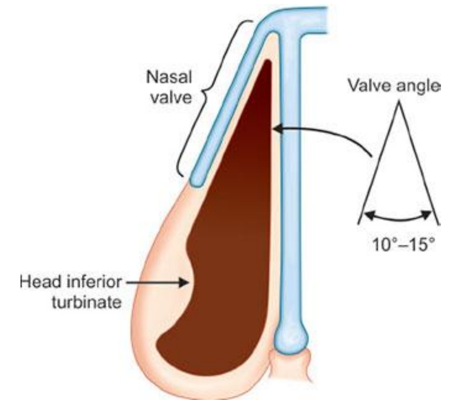
Function







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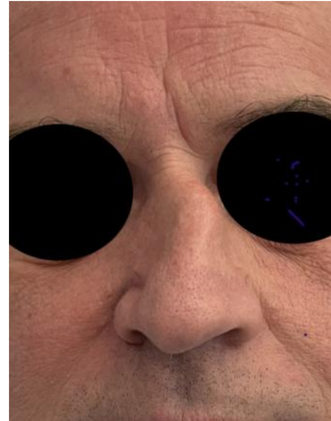
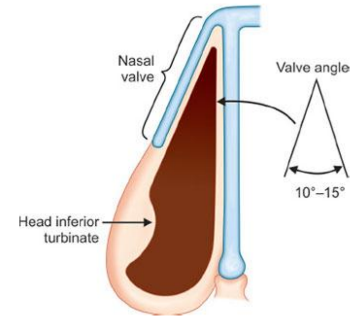
Assessment

- Septum,Inner nasal Valve,Tip.
- Deviation characteristic ,Location ,and extend.
- Impact on external shape.
- Rhinitis?Polyposis?....etc
- Further investigation ..ct scans!





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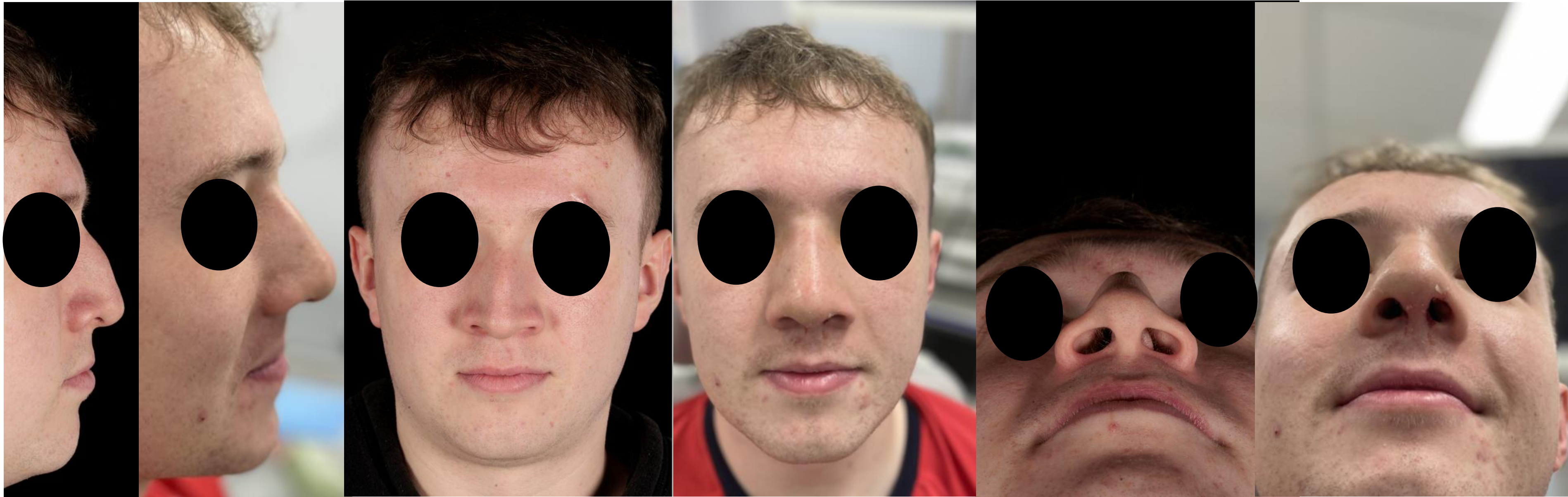
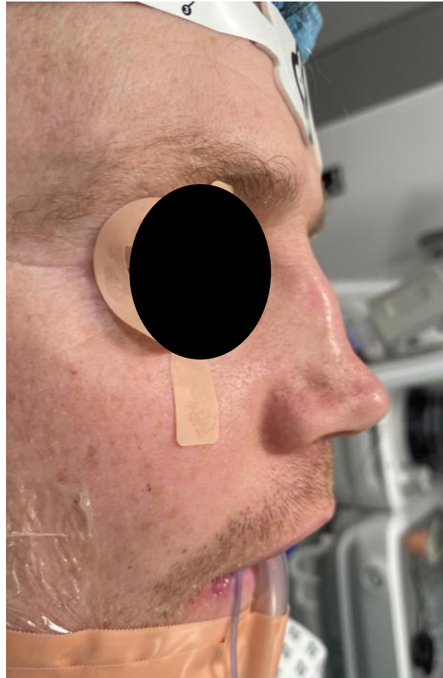
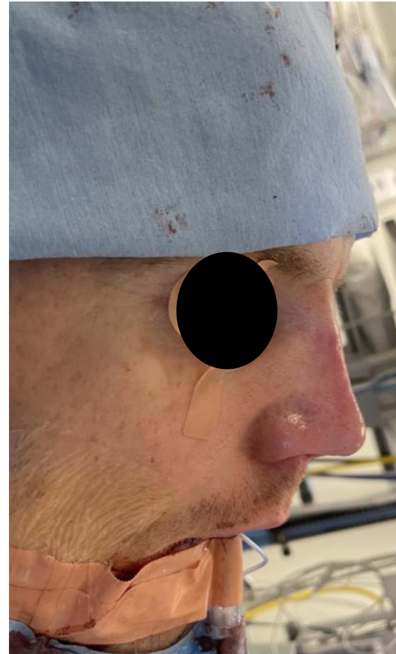
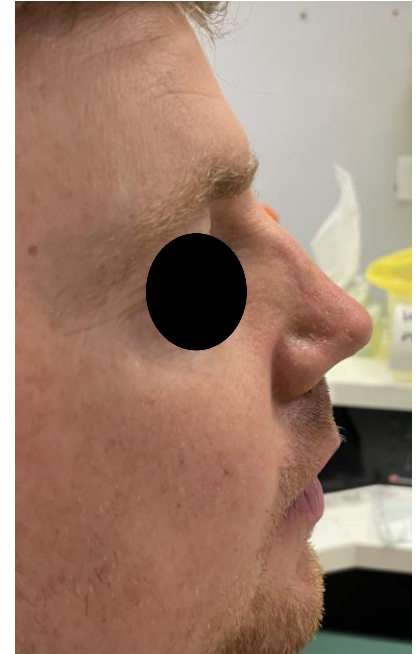
Primary Sport Injury



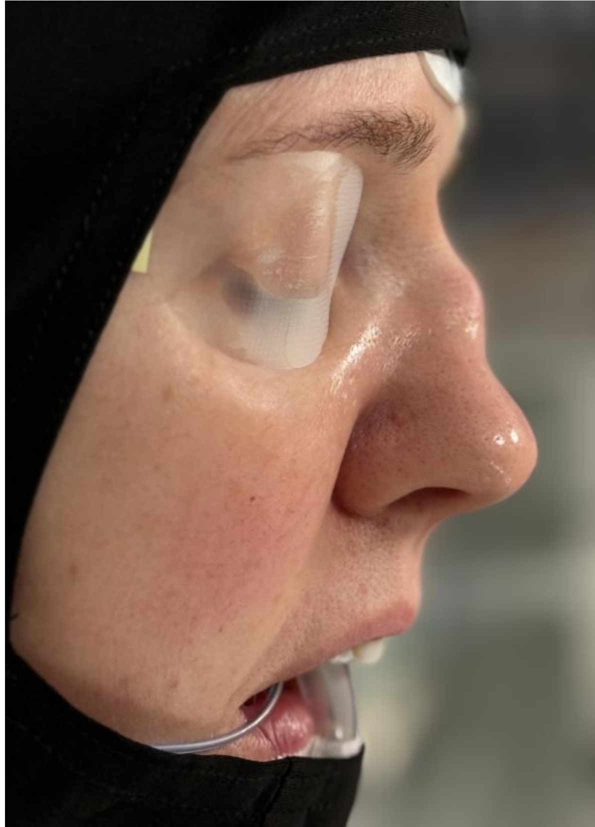
Post septoplasty infection Saddle nose







GPA Saddle nose



POST OPERATIVE CARE PACKAGE

Post Operative care

Immediate Post-Op Care (Days 1–7)

- **Head Elevation:** Sleep with your head elevated on 2–3 pillows for at least the first week to reduce swelling.
- **Ice Packs:** Apply cold packs or frozen peas to the cheeks/eyes (not directly on the nose) for 10–20 minutes at a time.
- **Gauze Changes:** Change the drip pad (moustache dressing) under your nose as needed for bleeding/drainage.
- **Nasal Care:** Do **not** blow your nose for at least 1–2 weeks. If you must sneeze, do it with your mouth open.
- **Cleaning:** Clean the outside of the nostrils with cotton swabs dipped in water/hydrogen peroxide if crusting occurs.

Use saline nasal sprays to keep the nose moist.

Activity Restrictions (2–6 Weeks)

- **Rest:** Rest at home for the first few days, but engage in light walking indoors to prevent blood clots.
- **Physical Strain:** Avoid heavy lifting (>15kgs) and strenuous exercise for at least 2–3 weeks.
- **Contact Sports:** Avoid contact sports or risks of hitting the nose for 6 weeks, or up to 3 months.
- **Smoking/Alcohol:** Avoid smoking as it impairs healing.
- **Glasses:** Avoid wearing glasses or sunglasses that rest on the bridge of the nose for 4–6 weeks.

AR

CRS

Rhinoplasty

ENT Services in Beacon – Neck Lumps / Globus

Robbie Woods
Consultant ENT / Head & Neck Surgeon
Honorary Associate Professor in RCSI

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THIS IS MODERN MEDICINE

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Straw Poll

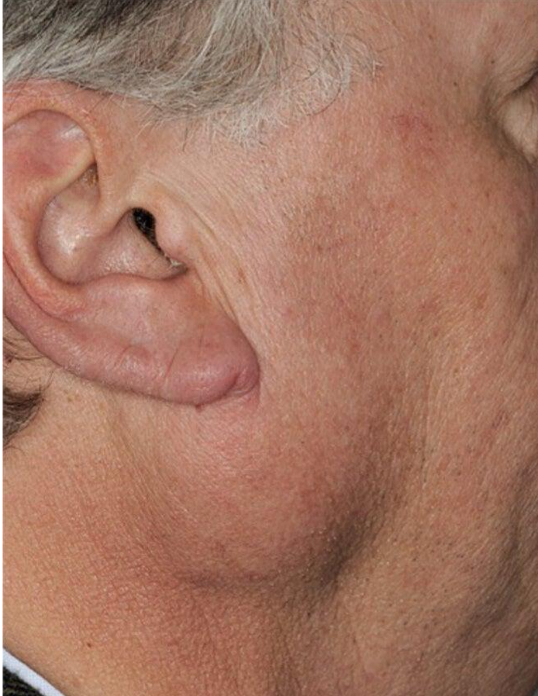
STRAW POLL

WHICH DO YOU PREFER?

☐ FLEXIBLE

☐ STRAIGHT

I've a swelling in my neck



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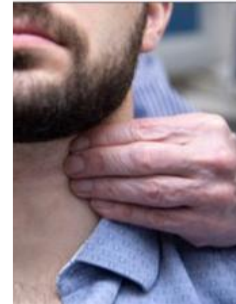
I've a swelling in my neck

Age
Location / size / duration of neck mass
Occurrence of symptoms
Acute symptoms- pain, sore throat, dysphagia, dysphonia
Red flag symptoms
B symptoms
Discharge sinus / fistula
Trauma
Travel
Smoking & Alcohol
Radiation exposure
Associated medical conditions

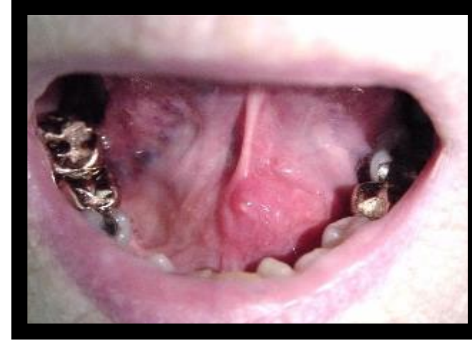


FBC
TFT
LDH, CRP
ANA, ANCA, RF, ACE, Ca, Sjögren's
HIV, TB, EBV, Bartonella, Toxo, Blood cultures

U/S +/- FNA
CT / MRI Scan

I’ve a swelling in my neck

- Conservative Treatment
  - Rehydration
  - Broad spectrum antibiotics
  - Analgesics
  - Improved oral hygiene
  - Sialogogues
  - Warm compress massage
- Interventional Treatment
  - Needle aspiration
  - Incision and drainage
  - Duct Marsupialisation
  - Sialendoscopy
  - Submandibular gland excision



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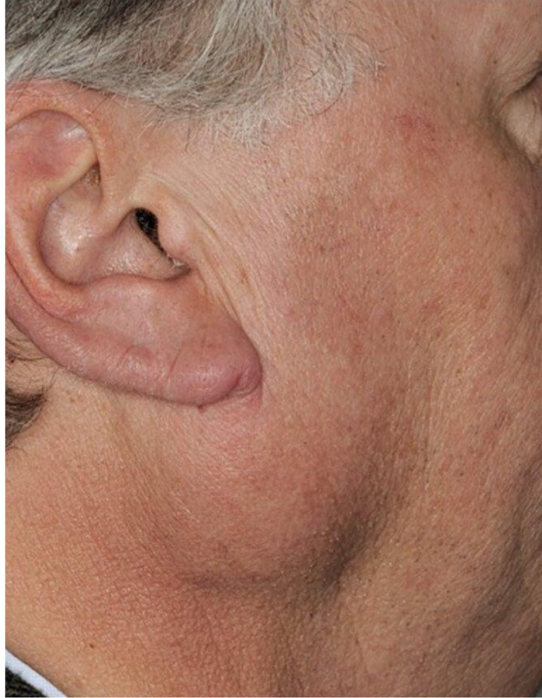
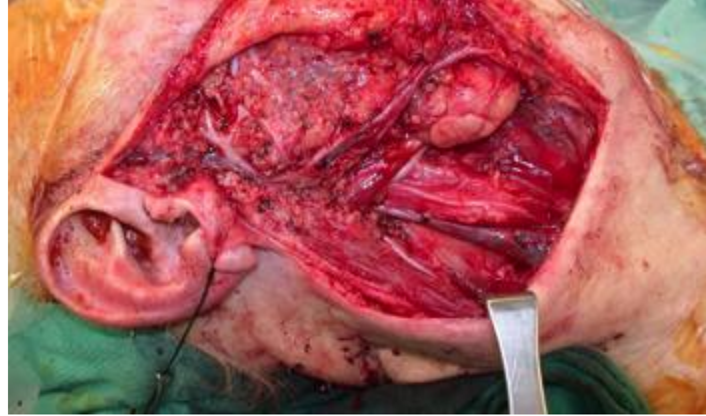
I've a swelling in my neck





I can feel something in my throat

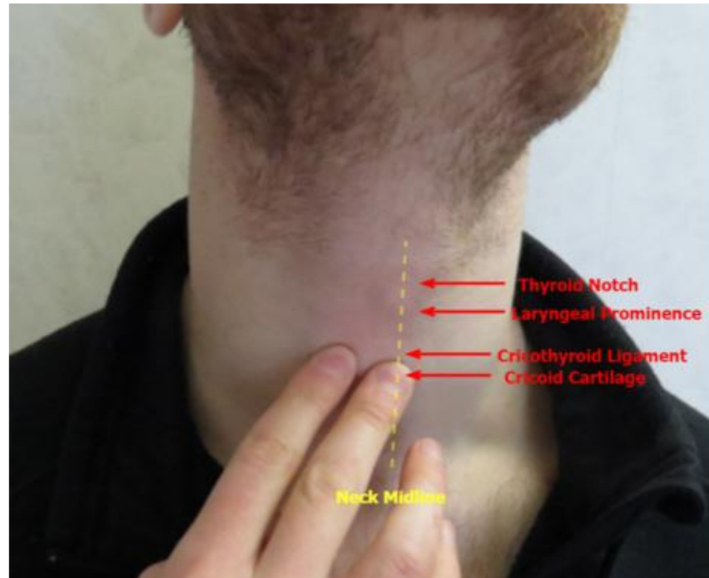
Many causes

Need to rule out serious pathology

Progressive dysphagia, Odynophagia, Unintentional weight loss, Persistent hoarseness, Haemoptysis, Neck mass, Significant smoking/alcohol history

Central

Worse on dry swallow



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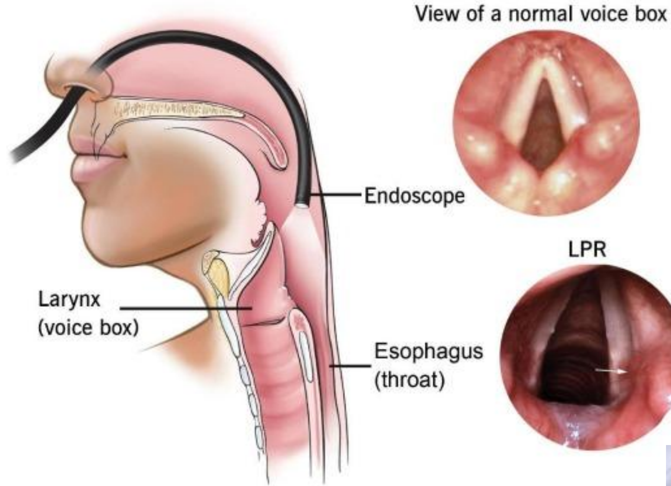
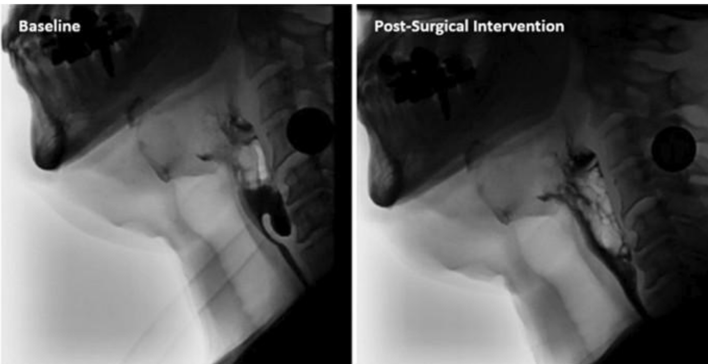
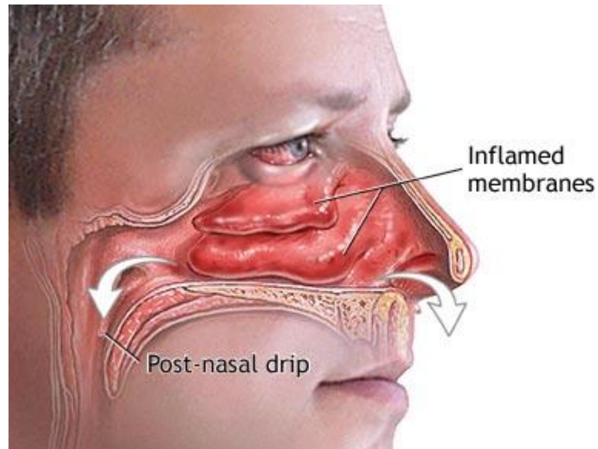
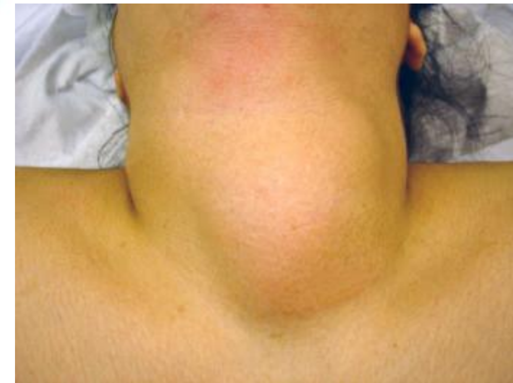
I can feel something in my throat



Scope +/-
Ultrasound
Contrast Swallow

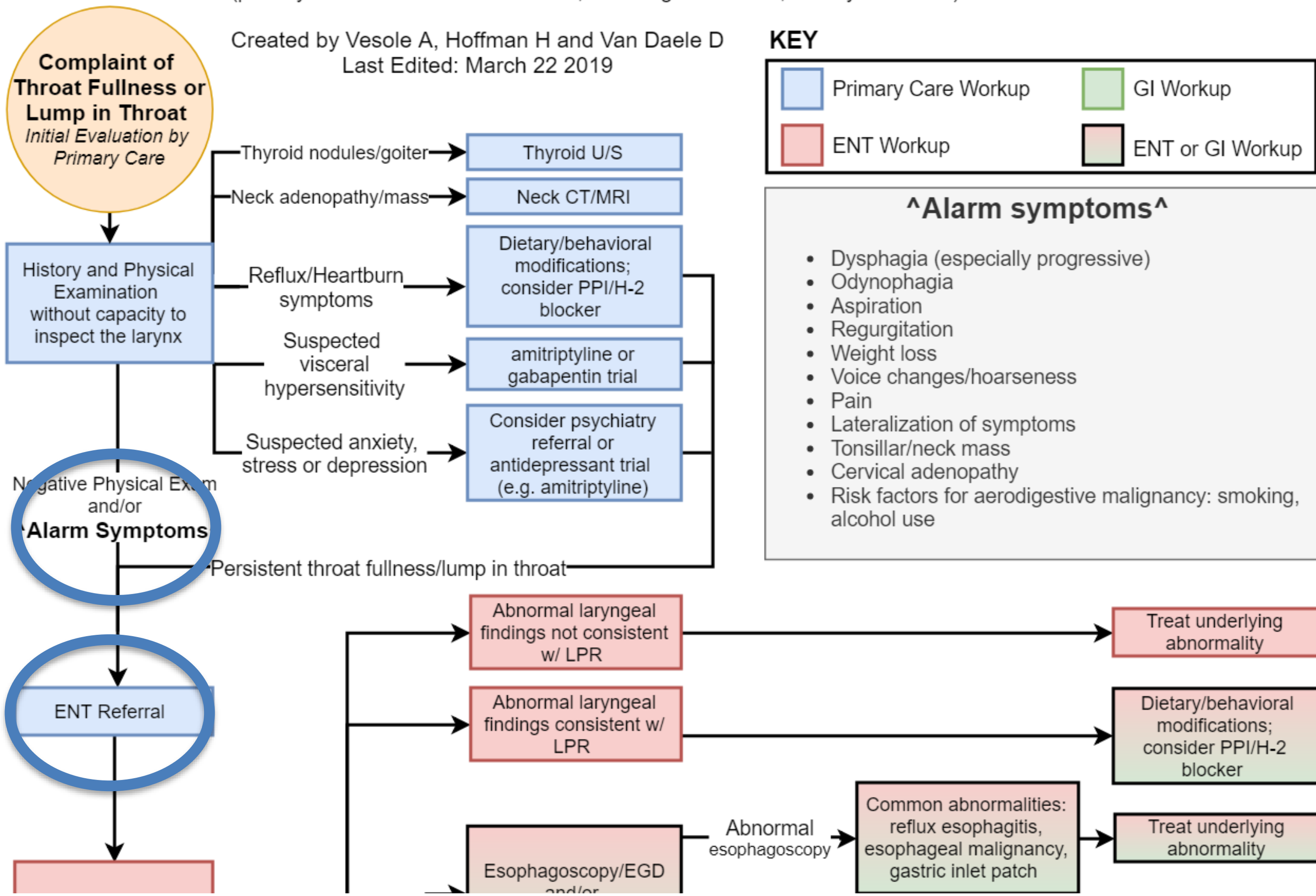






Algorithm for the Evaluation and Management of Globus Sensation

(primary references: Kumar et al 2013, Selleslagh et al 2013, Harvey et al 2018)



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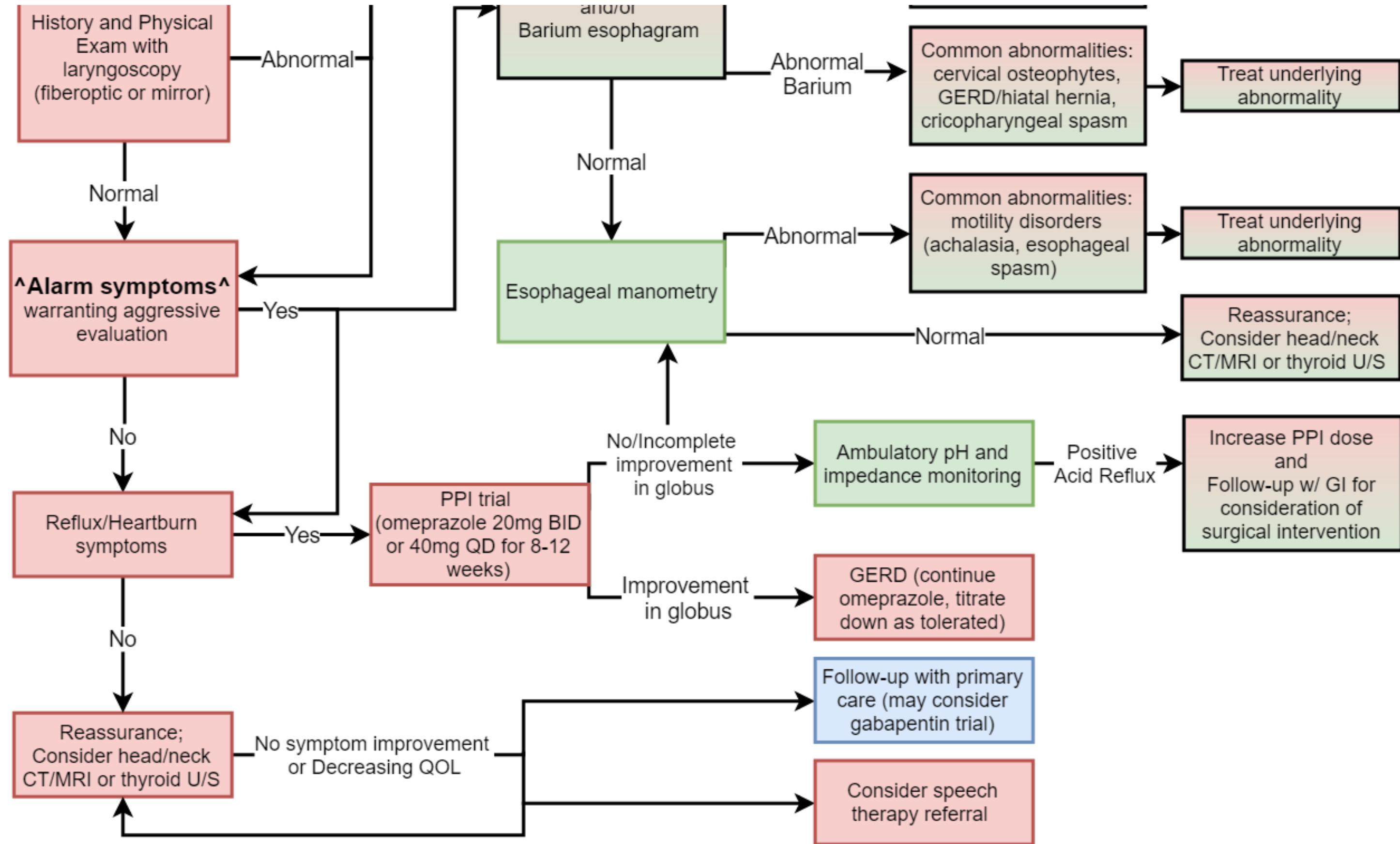

Abbreviations: BID= twice daily; CT= computed tomography; ENT= Ear, Nose, Throat; EGD= esophagogastroduodenoscopy; GERD= Gastroesophageal Reflux Disorder; GI= gastroenterology; LPR= laryngopharyngeal reflux; MRI= magnetic resonance imaging; PPI= proton pump inhibitor; QD= once daily; QOL= quality of life;U/S= ultrasound; w/o= without

***Desgined with complaint of throat fullness ("lump in throat") initially presenting to primary care practitioner.**

Questions