Pulse Clinical

Take-home points

- Optimal treatment of idiopathic recurrent epistaxis in children remains unknown, but start with an antibiotic cream twice daily for four weeks.
- Patients who may benefit from tonsillectomy are those who suffer five or more episodes of tonsillitis a year, are symptomatic for at least a year, and in whom episodes are sufficiently disabling to prevent normal functioning.
- The key step in managing patients who snore is to identify those with OSA.
- Patients with an Epworth score of 10/24 or more, patients who are sleepy in dangerous conditions, for example driving a heavy goods vehicle, and patients with co-existent COPD should be referred to a sleep medicine unit without waiting for lifestyle modifications to take effect.

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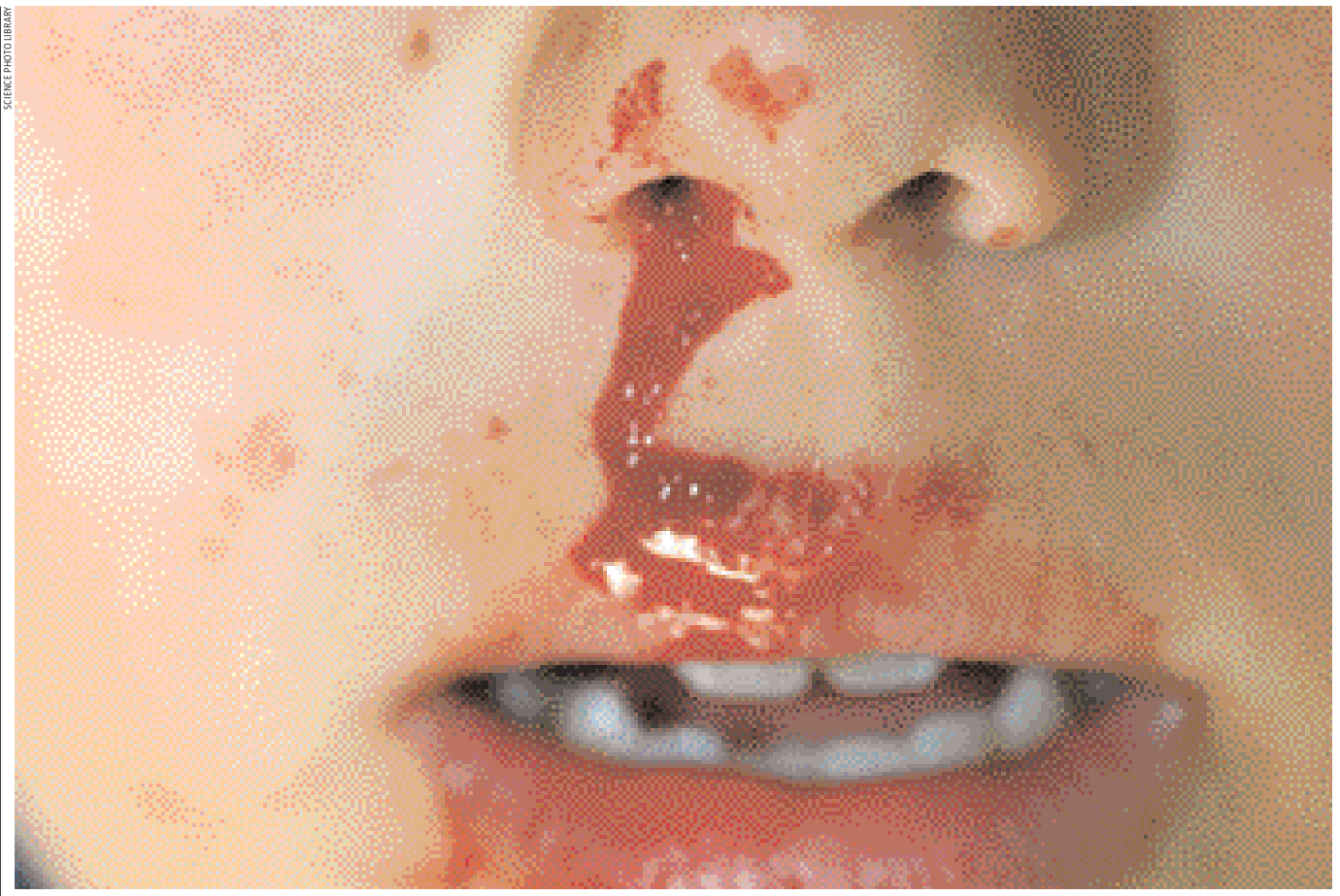

Topical antibiotics are as effective as cautery in recurrent epistaxis

NEED TO KNOW

NOSE AND THROAT PROBLEMS

In the second article of a two-part feature, specialist registrar Dr Jeeve Kanagalingam answers key questions posed by GP Dr Sonia Barros D'Sa

1 Does silver nitrate cautery really work for recurrent epistaxis? Should we be doing this? Are topical nasal antibiotics more likely to be effective?

A Cochrane review in 2004 eloquently concluded that the optimal treatment of idiopathic recurrent epistaxis in children remains unknown. There are few good quality trials and none compare both types of treatment directly.

The one study that compared topical antibiotics with and without cautery found that cautery did not confer additional benefit over antibiotic creams.

This study had only 50 children in it, having lost more than a fifth of subjects to follow-up. Practically, it would seem sensible:

- first, to educate patients about predisposing factors such as digital trauma, and simple first-aid measures to deal with nosebleeds
- second, to start an antibiotic cream to be used twice daily for four weeks
- finally, to refer to ENT for possible cautery.

It is important to treat underlying nasal allergies that may predispose young children to nose picking.

Beware of the young boy with repeated severe epistaxis who may have a juvenile angiofibroma in the nasopharynx. When prescribing antibacterial creams remember that Naseptin contains arachis oil and is contraindicated in children with peanut allergy.

2 Patient perception is that tonsillectomy is rarely, if ever carried out – although many parents are aware that everyone seemed to have this operation when young. What should be our referral criteria for recurrent tonsillitis?

The referral criteria in the UK for tonsillectomy follow SIGN guideline recommendations. These are grade C recommendations based on evidence of varying quality – underlining the lack of good research in this area. Patients who may benefit from tonsillectomy are those who suffer five or more episodes of tonsillitis a year, are symptomatic for at least a year and in whom episodes are sufficiently disabling to prevent normal functioning.

There are other criteria for tonsillectomy which include proven obstructive sleep apnoea (OSA), two episodes of peritonsillar abscess (quinsy) and suspected malignancy.

3 What should our referral criteria be for adenoidectomy?

There are few absolute indications for

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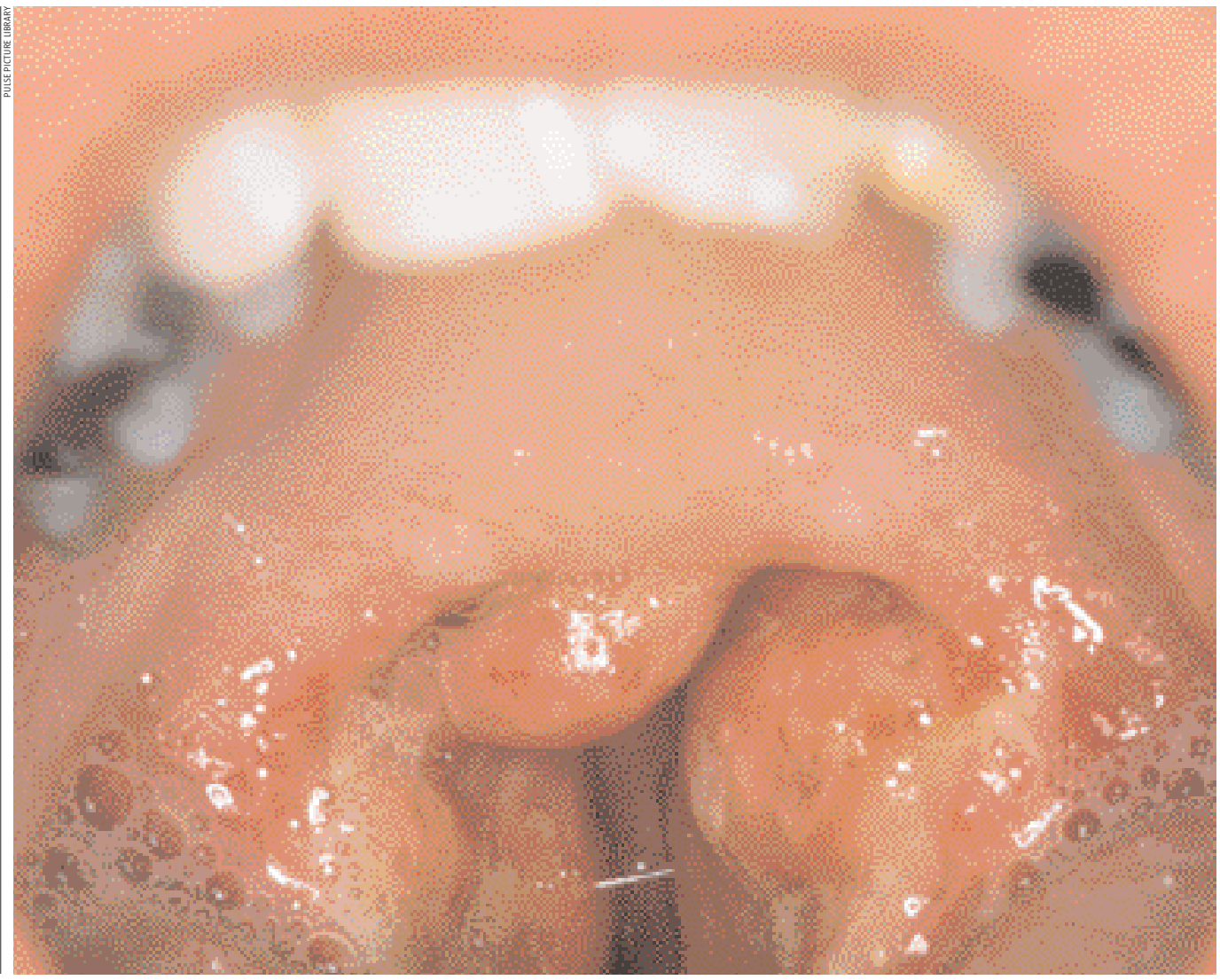
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If tonsillitis is recurrent, patients may need referral for tonsillectomy

adenoidectomy and therefore the referral criteria are difficult to define. It is certainly indicated for OSA, particularly when there is failure to thrive. However, when there is simply nasal obstruction with snoring, the risks of intervention are often difficult to justify.

In the treatment of glue ear, there is mounting evidence that adenoidectomy reduces glue ear recurrence rates when grommets extrude. This was established in the 1980s by studies undertaken by Richard Maw in Bristol, and more latterly in the Trial of Alternative Regimes of Glue Ear Treatment (TARGET – unpublished data). There is also unpublished data to show adenoidectomy improves general and respiratory health outcomes in children having this as part of ventilation tube insertion.

4 How likely is a persistent sore throat to be caused by acid reflux? Can we usefully distinguish this if someone doesn't have GORD symptoms?

Laryngopharyngeal reflux (LPR) causes symptoms of hoarseness or croakiness, persistent throat clearing with irritation, a dry cough and thick sticky mucus. Episodes of heartburn (retrosternal burning chest pain and a sore throat) are in fact less common. A patient presenting with sore throat alone without any other symptoms mentioned must be carefully evaluated to exclude other pathology. This is particularly so in those at high risk of head and neck cancers such as smokers and heavy drinkers.

In essence, the presence or absence of GORD symptoms is no guide to the likelihood of LPR. Barium swallows – even with the siphon test – are unreliable. The only true indicator of LPR is ambulatory 24-hour pH manometry, which is undertaken in most gastroenterology units.

The larynx and pharynx is irritated by acid and other gastric secretions such as pepsin. ENT surgeons rely on signs of mucosal oedema in the posterior glottis to confirm suspicions raised by a good history.

It is reasonable to treat these patients with advice about diet, posture and weight reduction. A proton pump inhibitor is indicated in more severe cases and should be continued for at least two months.

5 Snoring: once we have addressed lifestyle issues, what would be the next step to help patients and their partners?

The key step is to identify patients who suffer from OSA. The useful leads are a reliable history of breath cessation for at least 10 seconds, daytime sleepiness and waking up feeling unrefreshed with a headache. The Epworth Sleepiness Scale is a quick and reliable tool to assess daytime sleepiness (see box top right). There is good evidence linking OSA to the elevation of mean BP with subsequent hypertension. Treating OSA with nasal continuous positive airway pressure (CPAP) masks reduces systemic BP.

Those who do not have OSA are often called 'simple' snorers. There is, however, an intermediate group that may be termed 'sleepy' snorers. They suffer from micro-arousals during sleep, depriving them of a good night's rest. The condition is termed upper airways resistance syndrome (UARS).

SIGN has published recommendations on the management of OSA in adults based on the available evidence. It is advised that patients with an Epworth score of 10/24 or more, patients who are sleepy in dangerous conditions, for example driving a heavy goods vehicle, and patients with co-existent COPD should be referred to a sleep medicine unit without waiting for lifestyle modifications to take effect.

In the remaining low-risk patients, snoring may be causing disastrous marital disharmony and should be taken seriously.

6 Do ENT operations have a high success rate and are there significant risks of side-effects? Is there a wide range of operations offered, especially with lasers, and are there good online resources where patients can read up on this?

ENT procedures for snoring are many and varied. They all aim to improve airway patency and therefore reduce snoring. The majority of snoring emanates from the soft palate, which is what most procedures target. They include uvulopharyngopalatoplasty (UPPP), laser-assisted uvulopalatoplasty (LAUP) and the Celon palatoplasty using radio-frequency interstitial thermotherapy (RFITT).

Snoring may also be caused by tonsillar hypertrophy or tongue base collapse. The latter may be improved by advancing the jaw with the aid of a night-time jaw splint. There are also various surgical procedures that reduce the bulk of the tongue base or advance the mandible.

A blocked nose is probably not a major contributor to snoring. But it does cause patients to breathe through their mouth, which in turn causes more palatal flutter.

Success rates of the various ENT procedures for snoring are in the 60-80% range, but many studies are too short in follow-up and use subjective outcome measures.

For more information, direct patients to the website of the British Snoring and Sleep Apnoea Association (www.britishsnoring.co.uk).

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'Snoring may be caused by tonsillar hypertrophy or tongue base collapse'

EPWORTH SLEEPINESS SCALE

Age:

Sex:

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you. Choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

- Sitting and reading ☐
- Watching TV ☐
- Sitting inactive in a public place (such as theatre or meeting) ☐
- As a passenger in a car for an hour without a break ☐
- Lying down to rest in the afternoon when circumstances permit ☐
- Sitting and talking to someone ☐
- Sitting quietly after a lunch without alcohol ☐
- In a car, while stopped for a few minutes in traffic ☐

Total

0-10 Normal
10-12 Borderline
12-24 Abnormal

WHAT I WILL DO NOW

Dr Barros D'Sa responds to the answers to her questions

- I will try antibiotic cream in children who present with epistaxis before referral to ENT for cautery.
- I will use the Epworth score to assess snorers and refer them to the website.
- I will try a PPI for patients with a persistent sore throat, especially if they have a red throat with no symptoms/signs of infection.
- I will check blood pressure and assess cardiovascular risk in snorers.

Dr Sonia Barros D'Sa is a GP in Hampshire