Paediatric Ear Nose and Throat Specialist Clinics at Western Health:

Western Health provides the following Specialist Clinics for patients under the age of 18 years who require assessment and management of Ear, Nose, and Throat (ENT) conditions. Patients will be triaged by a Paediatric ENT Consultant or Registrar into management pathways according to specific clinical requirements.

These referral guidelines are for Paediatric Specialist Clinics provided at Joan Kirner Women's and Children's at Sunshine Hospital only.

Referrals may be triaged to alternative Paediatric Specialist Clinics at Western Health.

Please refer to the ENT – Children statewide referral criteria for information that must be provided in the referral: ENT - Children | health.vic.gov.au

Conditions not seen by paediatric ENT specialists at Western Health:

1. Ears
    - New diagnosis of microtia and/or atresia (please refer to The Royal Children's Hospital (RCH).
2. Paediatric OSA
    - Any child with a related syndrome or craniofacial abnormality (please refer to RCH).
3. Audiology referral please refer to: Western Health Audiology
    a) Paediatric neonatal assessment clinic
        - For assessment of infants ≤ 6 months of age referred under the Victorian Infant Hearing Screening Program (VIHSP) or with a known risk factor.

    b) Paediatric audiology clinic
        - For infants and children aged 6 months – 18 years, that require ONLY audiological assessment and management.

ENT Alarm Symptoms:

Acute conditions requiring immediate assessment – please refer the patient to the Sunshine Hospital Emergency Department.

Paediatric Ear

- Foreign body.
    - Any concern for a button battery (e.g. hearing aid battery) requires IMMEDIATE ENT review (< 2 hours) – high risk of causing burns and/or necrosis.
- Trauma.
- New onset facial nerve palsy.
- ENT conditions with associated neurological signs example: facial nerve palsy, profound vertigo and/or sudden deterioration in sensorineural hearing.
- Sudden, profound hearing loss.

Date: November 2025
Review Date: November 2028

- Otitis externa with uncontrolled pain and/or cellulitis extending beyond the ear canal despite treatment with oral antibiotics and ear drops, and/or ear canal is swollen shut.
- Auricular haematoma.
- Acute and/or complicated mastoiditis.
- Any suspicions of the complications of acute suppurative otitis media (ASOM) (i.e. mastoiditis (proptosis of pinna), meningitis).

Paediatric Nose

- Foreign body (button batteries).
  - Any concern for a button battery (e.g. hearing aid battery) requires IMMEDIATE ENT review (< 2 hours) – high risk of causing burn and/or necrosis.
- Trauma with other associated injuries i.e. other facial fractures e.g. orbit, nose
- Acute nasal fracture with septal haematoma
- Periorbital cellulitis with or without swelling, with or without sinusitis.
- Severe or persistent epistaxis

Paediatric Throat

- Foreign body (button batteries – inhaled or ingested)
  - Any concern for a button battery (e.g. hearing aid battery) requires IMMEDIATE ENT review (<2 hours) – high risk of causing burns and/or necrosis.
- Acutely enlarging neck mass with any associated airway symptoms (e.g. stridor, drooling, dysphagia, etc).
- Airway compromise: severe stridor/drooling/breathing difficulty/acute sudden voice change/severe odynophagia.
- Trauma.
- Abscess or haematoma (e.g. peritonsillar/quinsy, parapharyngeal, salivary, neck or retropharyngeal abscess).
- Post-tonsillectomy haemorrhage.
- Hoarseness associated with neck trauma or surgery.
- New onset hoarse voice and any airway obstructive symptoms.
- Acute tonsillitis with airway obstruction and/or unable to tolerate oral intake and/or uncontrolled fever.
- Rapid progression of obstructive sleep apnoea with significant parental concerns.

Paediatric Neck Mass

- Sepsis or acutely unwell due to infection.
- Infective lymphadenitis not responding to oral antibiotics.

Access & Referral Priority Ear, Nose and Throat:

The clinical information provided in your referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

URGENT

Appointment timeframe 30 days.

Throat

Stridor

- Moderate-severe non-life-threatening stridor with feeding difficulties and/or faltering growth.

Dysphonia / Hoarseness

- Hoarseness with moderate or severe stridor or respiratory distress should be seen in the emergency department.

Dysphagia

- Aspiration history with pneumonia requiring antibiotics.
- Proven aspiration on speech pathology assessment with no obvious explanation.

ROUTINE

Appointment timeframe greater than 30 days, depending on clinical need.

Note: Pending the severity of the condition some paediatric ENT referrals may be triaged as semi urgent $\leq$ 90 days at the discretion of the triaging ENT doctor.

Throat

Stridor

- Mild non-life-threatening stridor without feeding difficulties and/or faltering growth.

Obstructive sleep apnoea/Sleep disordered breathing

- Obstructive sleep apnoea with failure to thrive.
- Severe obstructive sleep apnoea proven on paediatric polysomnography or overnight oximetry.
- Sleep disordered breathing that persists for more than 3 months impacting on the child's behaviour:
  - Snoring/nasal obstruction and/or suspicion of sleep apnoea.
  - Adenotonsillar hypertrophy/obstruction and/or suspicion of sleep apnoea.
- Co-existing craniofacial abnormality.

Dysphonia / Hoarseness

- > 1 month of worsening or permanent moderate to severe hoarseness.
- Prolonged voice loss.
- Suspicion for papilloma or vocal cord palsy.

Tonsillitis – recurrent

- Recurrent tonsillitis with $\geq$ 7 documented episodes per year.
- Recurrent sore throat due to acute tonsillitis and any of the following:
  - 7 or more episodes in the last 12 months.
  - 5 episodes per year for 2 consecutive years.
  - 3 episodes per year for 3 consecutive years.
  - History of quinsy.
- Suspicious unilateral tonsillar solid mass with or without ear pain.

Ear

Otitis externa

- Confirmed otitis externa and persistent pain or hearing loss despite maximal medical management.

Ear

Otitis externa

- Confirmed otitis externa without pain and not responding to standard medical management.
- Associated dermatitis.

Hearing loss

- Recent diagnosis of unilateral/bilateral sensorineural hearing loss (SNHL) or congenital hearing loss.
- Recent diagnosis of permanent unilateral/bilateral conductive hearing loss.
- Conductive hearing loss associated with otitis media with effusion(OME) lasting > 3 months.
- Hearing loss in the setting of speech delay or educational learning delay.
- Asymmetrical hearing loss caused by ototoxic medicine(s).
- Hearing loss requiring hearing aid authorisation.

Perforated eardrum / chronic suppurative otitis media (CSOM)

- Perforated tympanic membrane and any of the following:
  - Ongoing pain.
  - Persistent drainage from the middle ear for > 6 weeks despite topical antibiotics.
  - Significant hearing loss 45db or greater in better hearing ear.
- Suspicion of cholesteatoma.
- Children with physical/structural/medical comorbidities (cleft palate, craniofacial abnormalities, diabetes SNHL).
- Failure of dry perforation to heal after 6 months.
- Bilateral dry perforation with mild hearing loss and no pain.

Otitis media – acute suppurative otitis media

- Suspicion of complicated otitis media e.g. cholesteatoma.
- Painful/smelly discharging ears despite topical antibiotics and/or oral antibiotics for at least 5 days.
- Non-painful discharging ear that has persisted for longer than 2 weeks that fails to settle with treatment.
- Children with physical/structural/medical comorbidities e.g. cleft palate, craniofacial abnormalities, diabetes SNHL
- Recurrent acute otitis media (AOM:)
  - >3 episodes in 6 months.
  - >4 episodes in 12 months.
- Acute otitis media(AOM) with ear drum perforation lasting longer than 6 weeks.

Nose/Sinus

<u>Epistaxis</u>

- Epistaxis with suspicion of tumour.

<u>Nasal allergic rhinitis / congestion / obstruction</u>

- Unilateral nasal obstruction with offensive and or bloody discharge.

<u>Nasal Fracture</u>

- Acute nasal fracture requiring surgical intervention (i.e. external bone displacement (best results for acute nasal fracture are achieved within 2 weeks from time of injury)).

Nose/Sinus

<u>Epistaxis</u>

- Epistaxis with either:
  - Unilateral nasal obstruction.
  - Diagnosed coagulation or platelet disorder.
- Unilateral epistaxis in adolescent male with suspicion of juvenile nasopharyngeal angiofibroma (JNA).
- Recurrent epistaxis not responding to medical management for > 6 to 8 weeks e.g. topical creams, no nose picking, manage allergic rhinitis.

<u>Nasal allergic rhinitis / congestion / obstruction / sinusitis</u>

- Nasal obstruction.
- Allergic rhinitis.
- Chronic rhinosinusitis (> 3 months of symptoms and failure to respond to treatment as per Health Pathways Melbourne).
- If patient 16 years old or greater, please refer to adult services at Western Health.

Neck Mass

- Neck mass that has any of the following:
  - increasing in size *and/or*
  - not responding to antibiotics *and/or*
  - persists for > 6 weeks.

Neck Mass

- Suspected thyroid mass *or*
- All other neck masses.

Condition Specific Referral Guidelines:

Key information enables Western Health to triage patients to the correct category and provide treatment with fewer visits to specialist clinics, creating more capacity for care. If key information is missing, you may be asked to return the referral with the required information.

Please refer to the ENT – Children statewide referral criteria for information that must be provided in the referral: ENT - Children | health.vic.gov.au

Condition:	Key Information Points:	Clinical Investigations:
Stridor	• History and physical examination, including birth history. • Feeding quality. • Details of any cyanotic and/or apnoeic episodes.	N/A
Snoring & obstructive sleep apnoea	• History and physical examination. • Tonsillar hypertrophy grading scale. • Details of obstructive sleep apnoea with co-existing craniofacial abnormality. • RCH OSA questionnaire: o Quality-of-life-survey-obstructiv-adenotonsillar-hyperplasia.pdf (rch.org.au)	• Recent paediatric sleep study (if available).
Tonsillitis	• History and physical examination include details of illness severity, antibiotic use, and response to treatment. • The number and timeframe of previous episodes. • Impact on school attendance.	N/A
Dysphonia / Hoarseness	• History and physical examination.	• Speech pathology report (if available).
Dysphagia	• History and physical examination.	• Speech pathology report. • Swallow studies if performed as part of speech therapy assessment.
Otitis externa	• History and physical examination. • Details of response to routine treatment with ear toilet, topical antibiotics, and ear wick.	• Ear swab M/C/S.
Hearing loss	• History and physical examination.	• Diagnostic audiology assessment results (readily available in WH catchment (or may refer to WH paediatric audiology)).
Otitis media – acute	• History and physical examination. • Duration of condition and previous medical and antibiotic management.	• Ear swab M/C/S if discharge present.

Condition:	Key Information Points:	Clinical Investigations:
Perforated eardrum / chronic suppurative otitis media		• Diagnostic audiology assessment results (readily available in WH catchment).
Recurrent Epistaxis	• History and physical examination. • Medical management to date.	• FBE/Coag result including Von Willebrand screening if suspected bleeding disorder.
Nasal allergic rhinitis/ congestion/ obstruction with failure to respond to medical management	• History and physical examination. • Medical management to date – details of intranasal steroid use and response.	• RAST/IgE results (allergic rhinitis).
Sinusitis	• History and physical examination. • Medical management to date.	• No imaging required before ENT assessment.
Nasal Fracture	• Standard History and physical examination. • Mechanism of injury and date of injury.	• No imaging required before ENT assessment (unless was required for suspected multi-trauma or other concern).
Neck mass	• History and physical examination including whether midline or lateral.	• Neck ultrasound with details of radiology provider. • TSH (if appropriate). • FBE (if available).

Date: November 2025
Review Date: November 2028