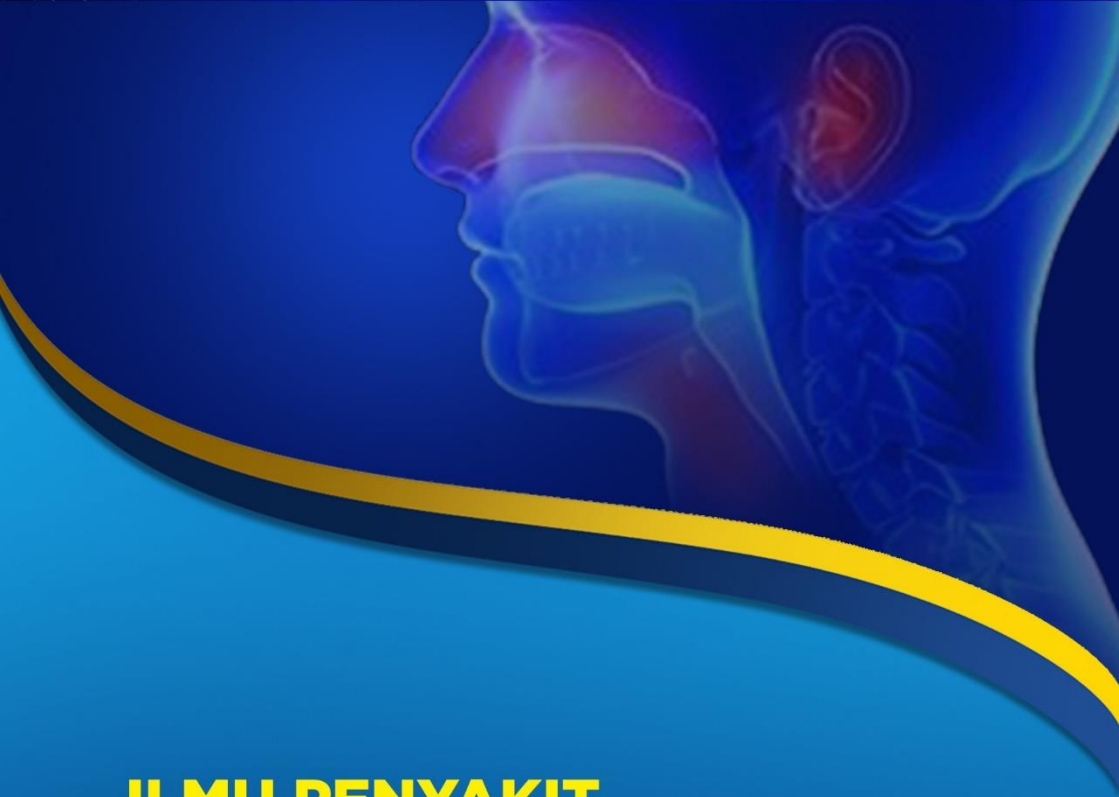

ILMU PENYAKIT
THT-KL

STUDY GUIDE

FAKULTAS
KEDOKTERAN
UNISMUH MAKASSAR

PROGRAM STUDI PENDIDIKAN DOKTER

FAKULTAS KEDOKTERAN

UNIVERSITAS MUHAMMADIYAH MAKASSAR

VISI

Menjadi program studi pendidikan dokter terkemuka tahun 2025 yang menghasilkan lulusan Islami dan unggul dalam bidang kegawatdaruratan medik

MISI

- Menyelenggarakan pendidikan dokter dengan pendekatan *student-centered learning* berbasis teknologi informasi untuk menghasilkan lulusan yang Islami dan unggul dalam bidang kegawatdaruratan medik.
- Melaksanakan penelitian untuk mengembangkan Ilmu pengetahuan, teknologi dan inovasi di bidang kegawatdaruratan medik dan kedokteran Islami.
- Melaksanakan pengabdian kepada masyarakat melalui penerapan Ilmu kedokteran kegawatdaruratan dan kedokteran Islami untuk meningkatkan derajat kesehatan masyarakat.
- Menyelenggarakan tata kelola program studi berbasis "Standar Penjaminan Mutu Internal".
- Menjalin kerjasama dengan *stakeholder* di dalam maupun di luar negeri untuk meningkatkan mutu catur dharma PSPD FK Unismuh

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بسم الله الرحمن الرحيم

SURAT KEPUTUSAN
DEKAN FAKULTAS KEDOKTERAN
UNIVERSITAS MUHAMMADIYAH MAKASSAR
NOMOR: 134 / Tahun 1439 H/ 2018 M

TENTANG

PEMBERLAKUAN BUKU PANDUAN BELAJAR (*STUDY GUIDE*)
PROGRAM PROFESI DOKTER FAKULTAS KEDOKTERAN
UNIVERSITAS MUHAMMADIYAH MAKASSSAR

Dekan Fakultas Kedokteran Universitas Muhammadiyah Makassar setelah:

MENIMBANG :
1. Bahwa dalam rangka kelancaran proses belajar mengajar mahasiswa program Profesi Dokter Fakultas Kedokteran Universitas Muhammadiyah Makassar, maka diperlukan adanya Buku Panduan Belajar (*Study Guide*).
2. Bahwa untuk pelaksanaan pada butir (1) di atas, maka pemberlakuan Buku Panduan Belajar (*Study Guide*) Program Profesi Dokter perlu ditetapkan dengan Keputusan Dekan.

MENGINGAT :
1. UU RI No. 20 Tahun 2003 tentang Sistem Pendidikan Nasional;
2. UU RI No. 14 Tahun 2005 tentang Guru dan Dosen;
3. UU RI No. 12 Tahun 2012 tentang Pendidikan Tinggi;
4. PP No. 4 Tahun 2014 tentan Penyelenggaraan Perguruan Tinggi dan Pengelolaan Perguruan Tinggi;
5. PP No.13 Tahun 2015 tentang Standar Pendidikan Nasional;
6. Pedoman Perguruan Tinggi Muhammadiyah Tahun 2012;
7. Statuta Universitas Muhammadiyah Makassar Tahun 2016;

MEMPERHATIKAN : Hasil Rapat Koordinasi Pimpinan Fakultas Kedokteran Universitas Muhammadiyah Makassar

M E M U T U S K A N

MENETAPKAN

PERTAMA : Menetapkan dan memberlakukan Buku Panduan Belajar (*Study Guide*) Program Profesi Dokter Fakultas Kedokteran Universitas Muhammadiyah Makassar sebagaimana tercantum dalam lampiran surat keputusan ini.

KEDUA : Buku Panduan Belajar (*Study Guide*) ini digunakan sebagai pegangan bagi mahasiswa pendidikan dokter tingkat profesi (koas) agar lebih terarah dalam mengikuti proses belajar mengajar maupun saat bertugas di setiap stase pendidikan klinik.

KEEMPAT : Keputusan ini berlaku sejak tanggal ditetapkannya dengan ketentuan apabila dikemudian hari terdapat kekeliruan dalam keputusan ini akan diperbaiki sebagaimana mestinya.

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بسم الله الرحمن الرحيم

Ditetapkan di : Makassar
Pada Tanggal : 07 Dzulqaidah 1439 H
20 Juli 2018 M

Dekan,

dr. H. Mahmud Ghaznawie, Ph.D., Sp.PA(K)

Tembusan:
1. Rektor Universitas Muhammadiyah Makassar;
2. Pembantu Rektor I Universitas Muhammadiyah Makassar;
3. Wakil Dekan I,II,III,IV Fakultas Kedokteran Universitas Muhammadiyah Makassar;
4. Ketua Program Studi Pendidikan Dokter Fakultas Kedokteran Universitas Muhammadiyah Makassar;
5. Ketua Program Studi Profesi Dokter Fakultas Kedokteran Universitas Muhammadiyah Makassar;
6. KTU pada Fakultas Kedokteran Universitas Muhammadiyah Makassar;
7. Arsip.

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بسم الله الرحمن الرحيم

Lampiran : Keputusan Dekan Fakultas Kedokteran Universitas Muhammadiyah Makassar
Nomor : 134 / Tahun 1439 H/ 2018 M
Tentang : **Pemberlakuan Buku Panduan Belajar (*Study Guide*)**

DAFTAR BUKU PANDUAN BELAJAR (*STUDY GUIDE*)
PROGRAM PROFESI DOKTER

NO.	JUDUL BUKU
1.	AL-ISLAM KEMUHAMMADIYAHAN (AIK)
2.	ANESTESIOLOGI
3.	BEDAH
4.	ILMU KEDOKTERAN FORENSIK
5.	ILMU KEDOKTERAN JIWA
6.	ILMU KESEHATAN ANAK
7.	ILMU KESEHATAN KULIT & KELAMIN
8.	ILMU KESEHATAN MASYARAKAT
9.	ILMU OBSTETRI & GINEKOLOGI
10.	ILMU PENYAKIT DALAM
11.	ILMU PENYAKIT MATA
12.	ILMU PENYAKIT THT-KL
13.	ILMU PENYAKIT SARAF
14.	KEGAWATDARURATAN
15.	RADIOLOGI

Ditetapkan di : Makassar
Pada Tanggal : 07 Dzulqaidah 1439 H
20 Juli 2018 M

Dekan,

dr. H. Mahmud Ghaznawie, Ph.D., Sp.PA(K).

BAB 1

PENDAHULUAN

1. Bagaimana meraih suskes dalam kepaniteran klinik I Kesehatan THT

Selamat datang dan selamat bergabung dalam komonitas pembelajaran di bagian ilmu kesehatan THT. Keberhasilan belajar di bagianTHT akan mendukung kompetensi anda sebagai dokter secara keseluruh. Karenanya, pastikan, bahswa anda meraih sekses di bagian THT ini.

Sekses berarti anda mengikuti semua proses pembelajaran dengan lancar dan dapat menikmati proses tersebut. Sukses juga berarti anda meraih kompetensi yang di harapkan sebagai bagian dari integral dari kompetesi dokter indonesia yang di formulasikan dalam 7 area kompetensi. Kompetensi spesifik akan dideskripsikan pada bagian lain buku ini. Sekses juga berarti anda membentuk diri sebagai dokter muslim yang mempunyai karakter sesuai dengan tujuan pendidikan di Universitas Muhammadiyah Yogyakarta. Akhir, sukses juga berarti terselesaikannya proses pembelajaran dan evaluasinya sesuai dengan waktu yang ditentukan.

Bagaimana cara meraih sekses dalam kepaniteran dibagian THT dapat dinyatakan secara ringkas sebagai berikut :

1. Yakinkan diri anda, bahwa anda adalah seorang sarjana kedokteran dan pastikan bahwa anda akan bersikap dan berpenampilan sebagai seorang sarjana keokteran. Rincian lanjut hal ini akan di sebut pada bagian lain
2. Yakinkan bahwa pencapaian kompetensi profesional anda menghajatkan upaya serius dan berkelanjutan.

Pembelajaran dalam tahap profesi adalah bagian integral dari pendidikan dokter yang anda jalani

3. Yakinkan diri anda bahwa anda siap dan mampu mengatasi perubahan situasi belajar dibandingkan tahap pendidikan sarjana kedokteran
4. Yakinkan bahwa anda telah menguasai teori yang berhubungan dengan masalah klinik yang anda hadapi. Review ulang teori-teori tersebut dengan bertolak dari masalah klinik riil akan lebih mengesan dibandingkan dengan belajar teori saja seperti yang pernah anda alami dalam tahap pendidikan sarjana
5. Yakinkan bahwa anda siap untuk menjadi pembelajaran seumur hidup. Perbahurui terus ilmu anda dengan mengikuti perkembangan teori dan dinamika penelitian di bidang kedokteran dengan mengakses artikel-artikel EBM yang relevan
6. Yakinlah, bahwa sekalipun pada tahap pendidikan ini anda tidak didik untuk menjadi seorang spesialis, tetapi pengetahuan dan keterampilan klinik yang akan anda dapatkan akan menentukan kompetensi anda secara keseluruhan sebagai dokter, setidaknya anda akan dapat berperan serta secara tepat dalam pengolahan masalah di bidang THT secara dapat dan proposional. Karena, nikmatilah proses pembelajaran ini, supersivor akan membantu anda dalam pencapaian kompetensi profesional melalui berbagai metode supervisi
7. Jagalah motivasi anda. Siaplah untuk mengerjakan tugas suatu prosedur yang sulit, mendiskusikan topik yang anda pilih setidaknya 20 menit. Siap untuk mendapatkan pasien tambahan, siaplah untuk tinggal lebih lama di bangsal jika di perlukan, siaplah untuk mencari informasi ilmiah yang di perlukan untuk mengolah pasien atau yang

diperlukan pasien. Semua itu menunjukan keingintahuan dan antusiasme anda

8. Kelola waktu dengan baik. Di bangsal, misalnya anda harus memeriksa pasien secara mandiri (bedside learning=follow up) sebelum supervisor memerika pasien sehingga anda dapat mencocokan temuan anda dengan hasil kunjungan supervisor (visite). Waktu-waktu luang harus anda gunakan dengan sebaik- baiknya karena sebenarnya waktu yang tersedia lebih sedikit dari pada hal yang harus anda kerjakan
9. Temukan cara yang efektif untuk mengelolah data pasien anda. Membuat rekan medis khusus dokter muda adalah cara efektif untuk mempraktekan langakah manajemen pasien seperti akan dideskripsikan pada bagian 2 bab ini. Catatan kecil atau resume berupa kartu indeks berdasarkan kasus mungkin akan sangat membantu
10. Biasakan sikap dan penampilan profesional, antara lain :
    a Pakeian yang relavan dengan profesi : tidak diperkenakan mengenakan jins, pakeian ketat atau yang menimbulkan kesan tidak rapi, sepatu hak (lebih dari 1,5 inchi), sandal atau sepatu sandal. Selalu kenakan sni jaz dengan rapi
    b Bersikap santun, berusaha untuk selalu tersenyum kepada pasien anda (apapun kondisi dan masalah yang anda hadapi), berusaha menghafal nama pasien dan menyapa mereka dengan nama mereka. Berikan empati kepada setiap pasien dankeluarga
    c Hargai supervisor, teman sejawat dan pegawai rumah sakit serta bekerja sama dengan mereka sebaik-baiknya. Perawat atau bahkan tenaga non medis mungkin akan menjadi guru anda yang baik sesuai dengan bidang mereka. Sapalah supervisor

anda dengan sebutan “Dok” atau “Pak” sesuai dengan kedudukan mereka sebagai bentuk penghargaan akademik kepada mereka

d Hargai hak-hak pasien, seperti kerahasiaan, hak otonomi mereka (misal untuk menerima atau menolak suatu terapi/tindakan). Jangan membicarakan masalah-masalah pasien di lorong rumah sakit atau kafe misalnya. Jangan mendiskusikan masalah pasien di depan orang lain tanpa pasien

2. Langkah manajemen pasien (SOAPIER)

a. Subyetik

Data subyetik diperoleh dengan anamnesis yang lengkap dan akurat. Anamnesia yang baik adalah yang dipandu oleh pengetahuan mengenai diagnosa banding untuk setiap keluhan utama dan pengetahuan mengenai diagnosa banding untuk setiap keluhan utama dan pengetahuan mengenai perjalanan alamiah penyakit setiap diagnosa bandingnya

b. Obyetik

Data obyetik diperolah dengan pemeriksaan fisik dan penunjung dasar. Data obyetik digunakan mengkonfirmasikan data subyetik.

c. Assesment

Berdasarkan data subyetik dan obyetik disusunlah hipotesis (diagnosa kerja atau diagnosa banding)

d. Planning (rencana tindakan)

Rencana meliputi rencana tindakan diagnosa, rencana pengolahan, rencana eduksi dll. Rencana disusun berdasarkan assesment. Rencana adalah tindakan

optimal yang sebaiknya dilakukan, meskipun tidak dapat dikerjakan

e. Implenmentasi
   Implenmentasi berarti pelaksanaan rencana tindakan. Apabila ada rencana yang tidak dikerjakan, dalam rekam medis dituliskan alasannya (misal karena OT menolak atau tak ada fasilitas)
f. Efaluasi dan Reassesment/revisi
   Data tambahan hasil implemintasi rencan menjadi bahan evaluasi melengkapi data sebelumnya. Dilakukan reassesment atau revisi assesment, jika perlu.

3. **Bagaimana menggunakan buku panduan belajar ini ?**

Buku ini adalah panduan untuk belajar di bagaian THT. Kompetensi yang ditampilkan adalah kompetensi dokter umum dibidang ilmu kesehatan THT. Bacalah secara keseluruhan daftar kompetensi maupun setiap bagiannya

Masalah klinis yang ditampilkan adalah 3 masalah utama yang ditentukan berdasarkan frekuensi penyakit maupun beban penyakit (burden of illenss) lainnya, seperti mortalitas, komplikasi atau beban ekonominya dan sebagainya. Urutan penyebutnya tidak menunjukan urutan frekuensi penyakit. Masalah-masalah lain dapat anda rujuk kepada berbagai buku rujukan dengan cara belajar yang serupa dengan buku panduan ini.

Secara demikian, buku panduan belajar ini akan tersusun atas bagian-bagian berikut:

Bab I :Pendahuluan
Bab II :Masalah penurunan pendengaran
Bab II :Masalah hidung pilek
Bab IV :Masalah sakit tenggorokan

Bab V :Masalah kegawatdaruratan kasus THT

Lampiran

Sebelum anda mulai kegiatan kepaniteran klinik, sebaiknya anda mencoba untuk menjawab pertanyaan yang disediakan pada setiap bab. Secara demikian, anda akan lebih siap ketika menghadapi kasus.

Algoritma kasus ditampilkan untuk membantu langkah diagnostik anda. Anda dapat membandingkan dengan algoritme lain yang dapat anda temukan pada berbagai guideline (clinical practice guideline).

Langkah selanjutnya, perhatikan kompetensi ketrampilan klinik yang harus anda capai. Beberapa prosedur klinik ditampilkan dalam buku panduan belajar ini.

Akhirnya untuk pengolahan kasus, anda harus memperhatikan perkembangan (EBM) dan tidak berhenti pada alur penatalaksanaan yang ada dalam buku ini maupun buku standar pelayanan medic.

Secara demikian, setiap bab pada bab II dan selanjutnya akan terdiri dari :

1) Tujuan pembelajaran
2) Pertanyaan dan persiapan dokter muda
3) Algoritme kasus
4) Daftar ketrampilan klinis
5) Deskripsi ketrampilan klinis

Selamat menikmati proses pembelajaran ini. Setiap kesulitan yang anda hadapi dapat dirujuk kepada supervisor maupun referensi mutakhir. Semoga sukses.

BAB II

PENURUNAN PENDENGARAN

A. Tujuan Pembelajaran

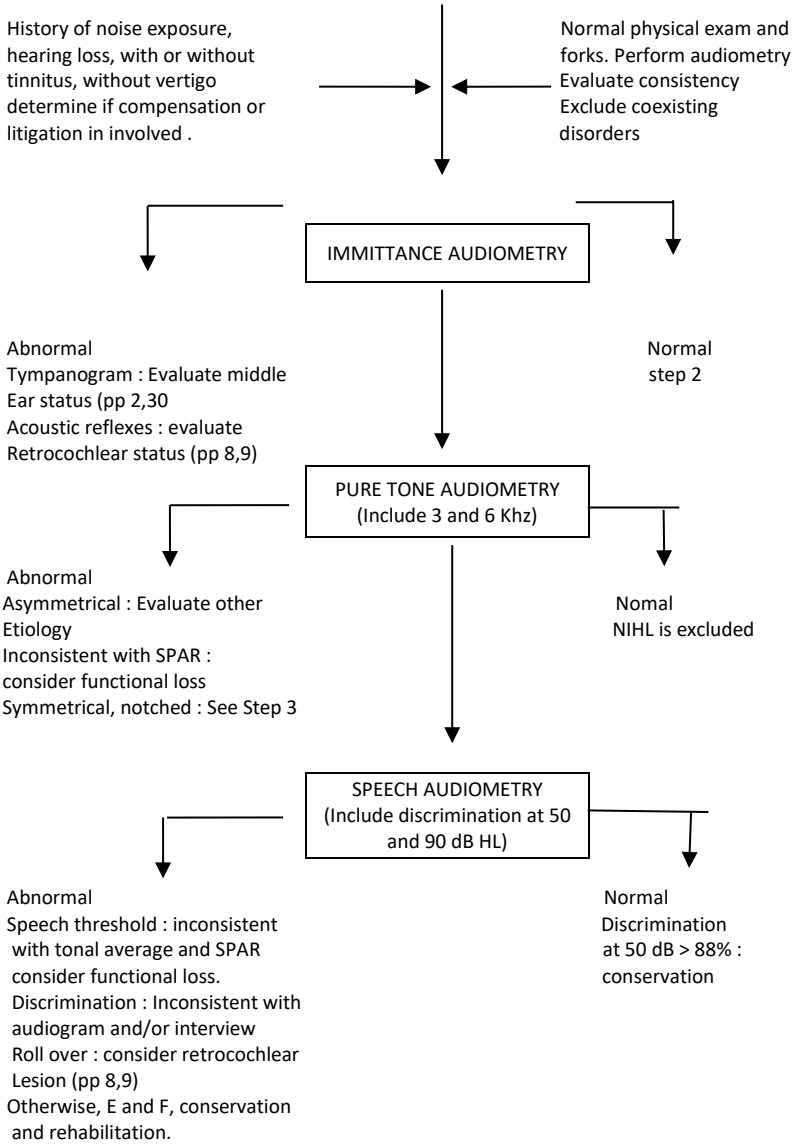
1. Mampu menjelaskan anatomi organ pendengaran
2. Mampu menjelaskan fisiologi pendengaran
3. Mampu melakukan pemeriksaan telinga luarw
4. Melakukan pemeriksaan pendengaran sederhana
5. Menentukan pemeriksaan tambahan yang diperlukan

B. Pertanyaan dan persiapan dokter muda

1. Keadaan apa saja yang menyebabkan gangguan/penurunan pendengaran?
2. Bagaimana karateristik pada masing-masing penyebab?
3. Bagaimana perjalanan penyakit tersebut?
4. Apa gejala-gejala lain yang menyertai/mendahului gangguan/penurunan pendengaran?
5. Pemeriksaan apa saja yang harus dilakukan untuk membuktikan hipotesis (diagnosis banding)?
6. Apa tujuan penanganan pada pasien dengan kelainan tersebut?
7. Penanganan apa yang anda pilih? Mengapa?
8. Bagaimana prognosis masing-masing kelainan tersebut?
9. Seberapa besar pengaruh kelainan tersebut terhadap permasalahan kesehatan masyarakat?

C. Alogaritma Kasus

HEARING LOSS



D. Daftar keterampilan (kognitif dan psikomotor)

1. Pemeriksaan kondisi telinga luar
2. Evakuasi ceruman prop
3. Pemeriksaan ketajaman pendengaran dengan voice test dan garpu tala

E. Penjabaran prosedur

1. Pemeriksaan kondisi telinga luar lihat pada petunjuk skills lab blok sensor
2. Pemeriksaan ketajaman pendengaran dengan voice test dan garpu tala liat pada petunjuk skills lab blok sensori.

F. Referensi

1. Ballantyne et al. A Synopsis of Otolaryngology. 1992. Freedberg I.M., Eisen A.Z., Wolff K., Austen K.F.5th ed, Mc Graw-Hill Inc. New York.
2. Bois LR. Fundamental of Otolaryngology. WB Saunders, Philadelphia. London. 1989.
3. Bailey JB. Textbook head and neck surgery otolaryngology 2nd eds. Basic science/ general medicine. New York: Lippincott-Raven Pub 1998.

BAB III

HIDUNG PILEK

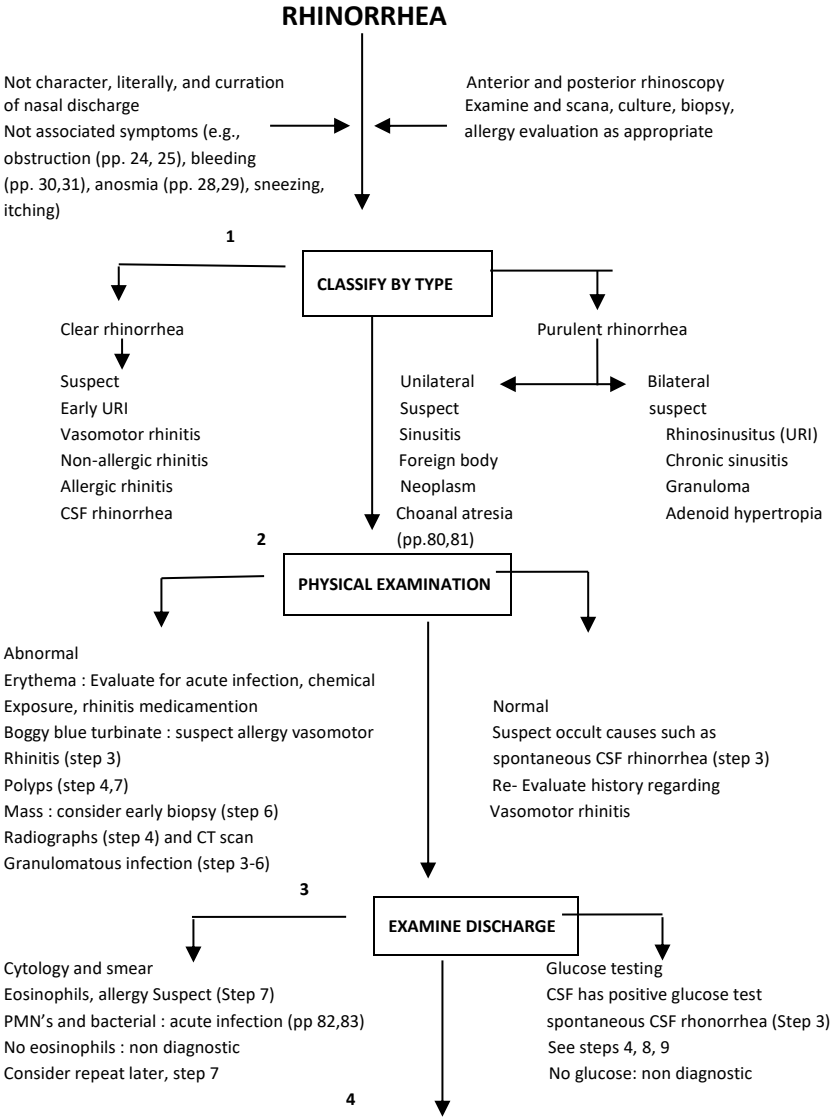
A. Tujuan Pembelajaran

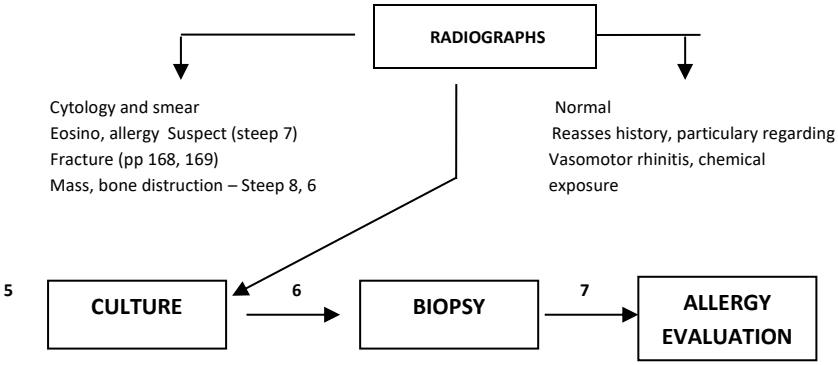
1. Mampu menjelaskan anatomi hidung
2. Mampu menjelaskan fisiologi hidung sebagai organ respirasi dan organ penghidu
3. Mampu menjelaskan keadaan-keadaan yang menyebabkan gangguan fungsi tersebut diatas
4. Melaksanakan pemeriksaan rinoskopi anterior dan rinoskopi postesior

B. Pertanyaaan dan Persiapan Dokter Muda

1. Keadaan apa saja yang menyebabkan hidung pilek? Kelainan-kelainan apa saja?
2. Bagaimana karateristik pada masing-masing penyebab?
3. Bagaimana perjalanan penyakitnya?
4. Apa gejala-gejala lain yang menyertai/mendahului hidung pilek?
5. Pemeriksaan apa saja yang harus dilakukan untuk membuktikan hipotesis (diagnose banding)?
6. Apa tujuan penanganan pada pasien dengan hidung pilek?
7. Apa yang anda pilih? Mengapa?
8. Bagaimana prognosis masing-masing kelainan tersebut?
9. Seberapa besar pengaruh kelainan terebut terhadap permasalahan kesehatan masyarakat?

C. *Alogaritma Kasus*





D. Daftar keterampilan (kognitif dan psikomotor)

1. Pemeriksaan Rhinoskopi anterior
2. Pemeriksaan Rhinoskopi posterior
3. Pemeriksaan patensi hidung

E. Penjabaran prosedur

1. Pemeriksaan hidung luar liat pada petunjuk skills lab blok sensor.
2. Pemeriksaan rhinoskopi anterior dan posterior liat pada petunjuk skills lab blok sensori.

F. Referensi

1. Ballantyne et al. A Synopsis of Otolaryngology. 1992. Freedberg I.M., Eisen A.Z., Wolff K., Austen K.F..5th ed, Mc Graw-Hill Inc. New York.

2. Boeis LR. Fundamental of Otolarygology. WB Saunders, Philadelphia. London. 1989.
3. Bailey JB. Texbook head and neck surgery otolaryngology 2nd eds. Basic science/ general medicine. New York: Lippincott-Raven Pub 1998.

BAB IV
SAKIT TENGGOROKAN

A. Tujuan pembelajaran

1. Mampu menjelaskan anatomi organ digesti bagian atas
2. Mampu menjelaskan fisiologi proses menelan
3. Mamau menjelaskan keadaan-keadaan yang bisa mengganggu proses menelan
4. Melakukan pemeriksaan orofarings sederhana
5. Mampu menentukan pemeriksaan tambahan yang diperlukan

B. Pertanyaan dan Persiapan Dokter Muda

1. Keadaan apa saja yang menyebabkan sakit tenggorokan?
2. Bagaimana karakteristik pada masing-masing penyebab?
3. Bagaimana perjalanan penyakit pada masing-masing penyebab?
4. Apa gejala-gejala lain yang menyertai sakit tenggorokan?
5. Pemeriksaan apa saja yang harus dilakukan untuk membuktikan hipotesis (diagnosis banding)?
6. Apa tujuan penanganan pada pasien dengan kelainan tersebut?
7. Apa yang anda pilih? Mengapa?
8. Bagaiman prognosis pada masing-masing kelainan tersebut?
9. Seberapa besar pengaruh kelainan tersebut terhadap permasalahan di masyarakat?

C. Algoritma kasur

Table3.Clinical and epidemiological findings and diagnosis of pharyngitis due to group A b-hemolytic streptococci (GABS)

Features suggestive of GABS as etiologic agent

- Sudden onset
- Sore throat
- Fever
- Headache
- Nausea vomiting and abdorminal pain
- Inflammation of pharynx and tosils
- Patchy discrete cervical nodes
- Patient aged 5-15 years
- Presentation in winter of early spring
- History of exposure

Features suggestive of viral etiology

- Conlunctivitas of viral etiology
- Coryza
- Cough
- Diamhea

NOTE. Clinical and epidemdogcal fidings erther individualy or collec tively cannot definitively predct the presence of group A d-hemodytic stirep tococcal pharyngtis then can however identify persons for whom the prsobalality ot group A b-hemolytic streptocoocol pheryngitis is high land forwhom thrcet culture or rapid antigen detection testing is indcatedi or low ithus nether is required

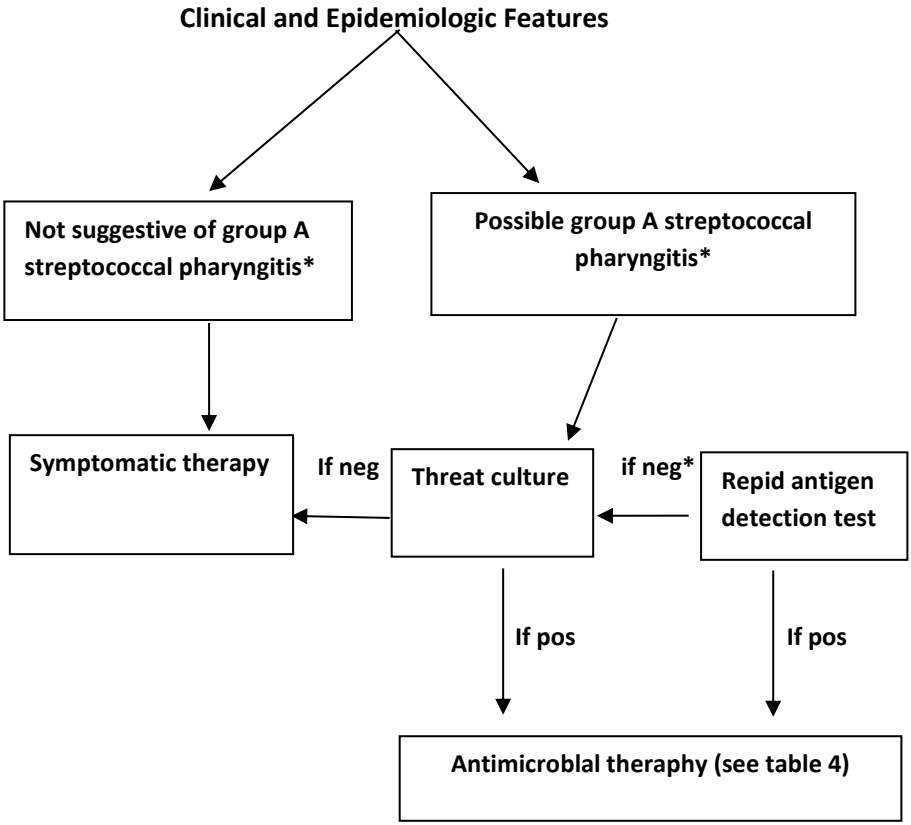


Figure 1. Diagnosis and management of acute pharyngitis the algorithin applies to incomplicated cases of acute pharyngitis Additional diagnostic and therapeintic ineasues may be neoessary fer patients writh suppirative complications le g. peritensillar abscess of oervical lymphadentisi of intection writh uncommion pharyngeal bacterial le g. (orynebacterium diphtheria neisseria gonrrhoeiis) is suspected *See the discussions in Diagnosis of Group A Streptococal Pharyngitis Neg. negative result pos. positive result.

D. Daftar keterampilan (kognitif dan psikomotor)

1. Pemeriksaan rongga mulut
2. Pemeriksaan orofarings
3. Pemeriksaan laringoskopi inderek

E. Penjabaran prosedur

Pemeriksaan rongga mulut, orofarings, dan laringoskopi indirek lihat pada petunjuk skills lab

F. Referensi

1. Ballantyne et al. A Synopsis of Otolaryngology. 1992. Freedberg I.M., Eisen A.Z., Wolff K., Austen K.F.5th ed, Mc Graw-Hill Inc. New York.
2. Bois LR. Fundamental of Otolaryngology. WB Saunders, Philadelphia. London. 1989.
3. Bailey JB. Textbook head and neck surgery otolaryngology 2nd eds. Basic science/ general medicine. New York: Lippincott-Raven Pub 1998.

BAB IV
KEDARUTAN DI BIDANG THT

A. Tujuan pembelajaran

1. Mampu menjelaskan keadaan-keadaan kedauratan di bidang THT
2. Mampu mendiagnosa kedaruratan dibidang THT
3. Mampu melakukan pertolongan pertama pada keadaan tersebut di atas

B. Pertanyaan dan Persiapan Dokter Muda

1. Apa saja kedaruratan dibidang THT?
2. Bagaimana karakteristik pada masing-masing kondisi?
3. Bagaimana perjalanan penyakit pada masing-masing kondisi?
4. Apa tujuan penanganan pada pasien dengan kedaruratan di bidang THT?
5. Apa yang anda pilih? Mengapa?
6. Bagaimana prognosis pada masing-masing kedaruratan tersebut?

C. Algoritma kasus

NATIONAL REFERRAL GUIDELINES : ORL, HNS			
Diagnosis	**Evaluation**	**Treament Options**	**Referral Guidelines**
Acute Nassal Fracture	1.Immediate changes : Oedema, ecchymoses, Epistaxis. 2.Evaluate for septal fracture Or septal haematoma 3.Nasal Xrays unnecessary 4.Chek tor malar/maxilla # 5.Facial bone Xrays if suspect tacial #.	1.Early treatment : cool Compresses to reduce Swelling 2.Re-evaluate at 3-4 days to ensure nose looks normal and if breathing is normal	Immediate Otolaryngology Referral it acute septal haematoma (usually signiticant nasal obstruction) - category 1 Otolaryngology referral initiated now if there is a external nasal deformity. Note : Nasal fractures must be reduced <2 weeks for best result
Foreign Bodies	a) Acute : history alone or visible on examination b)Chronic : Persistent, of tensife, unilateral nasal discharge in a child	Don't attempt removal unless Experienced and with good equipment	Urgent referral for removal - category 1 Immediate referral if battery (category) Otolaryngology referral for removal – category 2
Specitis problems include: Epistaxis -persistent or recurrent	1.Determine whether bleeding is unilateral or bilateral. 2.Determine whether bleeding is anterior or posterior 3.Determine if any bleeding diathesis or hypertension is	Immediate control may occur with: 1.Pressure on the nostrils(>5 mins) 2.It bleeding is visible in little's area consider cautery with	Referral to an Otolaryngologist is indicated it: 1.bleeding is posterior category 1-2 2.Bleeding persists Category 1 Bleeding recurs Category 3

	present	silver nitrate (after applying topical anaesthesia) 3.Intranasal packing coated with antibiotic ointment only it done by appropriate person with good equipment. Atferwards – steam or humidification, Vaseline or bactroban for protective layer to prevent drying	

D. Daftar ketrampilan (kognitif dan psikomotor)

1. Tampon hidung anterior
2. Evakuasi benda asing di telinga, hidung dan rongga mulut
3. Trakeostomi

E. Pejabaran prosedur

Petunjuk cara pemasangan tampon anterior , evakuasi benda asing dapat diliat pada petunjuk skills lab

F. Referensi

1. Ballantyne et al. A Synopsis of Otolaryngology. 1992. Freedberg I.M., Eisen A.Z., Wolff K., Austen K.F..5th ed, Mc Graw-Hill Inc. New York.
2. Bois LR. Fundamental of Otolarygology. WB Saunders, Philadelphia. London. 1989.
3. Bailey JB. Texbook head and neck surgery otolaryngology 2nd eds. Basic science/ general medicine. New York: Lippincott-Raven Pub 1998.

LAMPIRAN KASUS-KASUS YANG PERLU DIRUJUK

National Referral Guidelines

SPECIFAL OTOLARYNGOLOGY, HEAD AND NECK SURGERY REFERRAL LETTER GUIDELINES
Midwives, Audiologist, ENT specialist nurses, audio-visual and mobile hearing caravan testers may refer but with reference to the patient's GP

Category definitions: these are recommended guidelines for health professional referring patients for assessments/treatment in a HHS.

1. Immediate -phone call
2. Urgent -within 2 weeks
3. Semi-urgent -within 8 weeks
4. Routine -within 26 weeks

Immediate and urgent cases must be discussed with the specialist or registrar in order to get appropriate prioritization and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

Note: *these national referral guidelines have been prepared to provide guidelines for referral to specialist otolaryngology services. They should be regarded as examples or guidelines for referring health professionals and are not an exhaustive list. They are not intended to preclude a referral where the diagnosis is unclear or a second opinion for management options is requested.*

They contain some management options to assist the general practitioner. It should be noted it is consensus document produced in the absence of hard evidence based guidelines.

The referring health professional should ensure that in using these national referral recommendations generally accepted clinical practice should be properly taken into account. If there is a conflict between the national referral recommendations and generally accepted clinical practice, then generally accepted practice should prevail.

NATIONAL REFERRAL GUIDELINES : ORL, HNS			
Diagnosis	Evaluation	Treament Options	Referral Guidellines
Pharyngeal, tonsil & Adenoid Acute Tonsillitis	Throatpain & odynophagia + any of:	1. Penicilin VK 25-	Acute referral it unable to Orally hydrate

	1. Fever 2. Tonsillar exudates 3. Cervical Lymphadenopathy 4. Positive Strept. test	50mg/kg/day for 10/7 2. Cephalosporin or macrolide it allergic to penicillin or it initial treatment tails.	Documented episodes: - 7 or more in the preceding 12 month - 5 per year in Preceding 3 years - 3 per year in preceding 3 years Persistent Strept. Carrier state Or without acute tonsillitis – category 4.
Peritonsillar Cellulitis/Quinsy	Abcesses take > 4 day to Develop: 1. Unilateral tonsillar Displacement 2. Trismus 3. Fever 4. Cervical lymphadenopathy 5. Server odynophagia	IM Penicillin (3 Megaunitis for adults) and review in 24 hrs.	Acute referral to Otolaryngologhy with: - Abscess – category 1 - Peritonsillar cellultis it not resolving- category 1 Elective tonsillectomy later in patients with preceding/subsequent tonsillitis/quinsy – category 4

NATIONAL REFERAL GUIDELINE : ORL, HNS			
Diagnosis	**Evaluation**	**Treatment Options**	**Referral Guidelines**
Chronic Tonsillitis	Frequent or chronic throat pain and odynophagia; may include: - Intermittent exudate - Adenopathy - Improvement with antibiotic	Augmentin 20-40mg/kg/day For 10/7 Clindamycin 10-25mg/kg/day for 10/7	Referral is indicated it problem recurs following adequate response to treatment – category 4
Mononucleosis/Viral pharyngitis	Throat pain and odynophagis with: - Fatigue - Membranous tonsillitis - Posterior cervical lymphanopathy - CBC, mono test	Supportive care Systemic steroids if severe dysphagia	Airways obstruction & dehydration – category 1 Consider medical assessment for continued symptoms for> two weeks
Adenoiditis/Hypertrophy	1. Purulent rhinorrhoa 2. Nasal obstruction +/ snoring 3. Chronic cough 4. +/- otitis media	At least two weeks of therapy with B-lactamase stable antibiotic: - Augmentin 20-40mg/kg/day QBH	1. Persisting symptoms and findings after two courses of antibiotic – category 4 2. Associated sleep apnoea category 3

Upper airways Obtruction from adenotonsillar hypertrophy (especially in children)	1. Mouth breating 2. Nasal obstruction 3. Dysphonia 4. Severe snoring +/-sleep apnoea 5. Daytime fatigue 6. Dysphagia/eating ditficulties 7. Weight +/- height below normal 8. Dental maldevelopment 9. Adenoid facies 10. Cor pulmonale	1. Optional lateral soft tissue X-ray of nasopharynx 2. Allergy evaluation where indicated	Referral indicated with any significant symptoms of upper airway obstruction especially sleep apnoea category 2
Croup & Epiglottis	See Paediatric Guideline		Refer Paediatrician
Tonsillar Haemorrhage	1. Spontaneous bleeding from tonsil 2. Post-tonsillectomy (secondary haemorrhage usually occurs within 2 weeks post op)	Bed rest and treat secondary infection with augment (or Ceclor)	Referral – category 2 Referral indicated if persists or recurs Immediate referral indicated if bleed persists, recurs or is significant – category 1
Neoplasm	Progressive enlargement of mass or ulceration in the oral cavity or pharynx. Often painless initially but may be pain odynophagia or dysphagia		Urgent referral indicated – category 2 Outpatient assessment

NATIONAL REFERAL GUIDELINE : ORL, HNS			
Diagnosis	**Evaluation**	**Treatment Options**	**Referral Guidelines**
HOARSENESS HOARSENESS : Associated with Upper respiratory Tract Infection	1. Throat pain, may radiate to ear 2. Dysphagia 3. Constitutional symptoms 4. Stridor/airways obstruction	1. Humiditication 2. Increase hydration 3. Voice rest, if possible 4. Antibiotics when appropriate 5. Inhalant steroids sprays 6. Tapering oral steroids	Otolaryngology referral indicated if: 1. Stridor or airways distress category 1 2. Associated with significant dysphagia- category 2. 3. Hoarseness present weeks – category 2-3
Hoarseness: Associated with Neck Trauma or Thyroid surgery	History of neck trauma preceding hoarseness. May or may not have: 1. Skin laceration 2. Ecchymosis 3. Tendernes 4. Subcutaneous emphysema 5. Stridor	Immediate treatment with: 1. Humiditication, oxygen 2. Parenteral andior inhaled steroids/neb adrenaline	**Immediate** Otolaryngology referral indicated in all cases – category 1
HOARSENESS : Associated with Respiratory Obstruction	Stridor	1. Immediate treatment with humidification; parenteral steroids/ neb,adrenaline 2. Soft tissue lateral of neck with neck hyperextended only if patient stable 3. Blood cultures if patient tebrile	Immediate Otolaryngology referral indicated in all cases- category 1

HOARSENESS : Without Associated Symptoms or obvious Aetiology	1. History of tobacco and alcohol use 2. Evaluation when indicated tor: - Hypothyroidism - Diabetes Mellitus - Gastro-oesophageal retlux - Rheumatoid disease - Pharyngeal/oesophageal tumour - Lung neoplasm	1. Humiditication 2. Increase tluid uptake 3. Voice rest, it possible 4. Antibiotics, where Appropriate 5. Inhalant steroid sprays 6. Treat any medical illnesses diagnosed on evaluation 7. Chest Xray	Otolaryngology referral is indicated if recent onset hoarseness persists over tour weeks despite medical theraphy - especially in a smoker – category 3
DYSPHAGIA	May include history or tindings of: 1. Foreign body ingestion 2. Gastro-oesophagel Reflux 3. oesophagel motility disorder 4. Sclero derma 5. Neoplasm 6. Thyromegaly	Diagnostic studies may include: - Soft tissue studies of the neck including lateral XR - Cest Xray - Barium swallow - Thyroid studies - Lab test tor autoimmune disease Management may include: - Antiretflux management - Speech-language therapy assessment	Otolaryngology referral indicated if: 1. Hypopharyngeal or upper oesophageal foreign body suspected (mind-lower oesophageal lesions and foreign bodies normally referred to general Surgery/Gastroenterology)- category 1 2. Dysphagia with hoarseness – category 2 3. Progressive dysphagia or persistent dysphagia tor three weeks – category 3

NATIONAL REFERAL GUIDELINE : ORL, HNS			
Diagnosis	Evaluation	Treatment Options	Referral Guidelines
NECK MASS Inflammatory (ie. paintul)	Complete head and neck examination indicated for site of infection Consider FNA if unsure of diagnosis Optional investigations (if indicated): 1. CBC 2. Cultures when indicated 3. Intradernal TB test 4. Possible cat scratch disease 5. HIV testing if indicated 6. Toxoplasmosis titre if indicated 7. Lateral Xrays of neck (hyperext) 8. Glandular fever monospot tests	1. Augment 20-40mg/kg/day 2. Clindamycin 10-25mg/kg/day	Otolaryngology referral indicated if mass persists for four weeks without improvement – category 2 Urgent referral if painless progressive of metastatic Carcinoma – category 1
Nonintlammatory (ie. paintess)	Complete head and nick exam indicated Consider ultrasound Open biopsy is contraindicated Is there dysponea hoarseness or dysphagia ?	Trial of antibiotic therapy may be considered if an inflammatory mass is suspected NB – 80% of all non – thyroid and non – inflammatory masses are malignant	Thyroid masses usually referred to a head and neck surgical department or surgeon – category 2-3
Thyroid Mass	Complete Head and neck exam indicated Is it a generalized or localized thyroid enlargement		Generalized Thyroid entargement with no compression symptoms can be

	Are there symptoms of dyspnonea hoarseness or dysphagia?		referrall to a thyroid clinic – category 3 Those with compressive symptoms or discrete swelling should be referral to ORL HNS _ category 2
SALIVARY GLAND DISORDERS Sialadentis/Siololithiasis	1. Assess patient hydration 2. Palpate floor of mouth for stones 3. Observe for purulent discharge from salivary duct when palpating gland 4. Evaluate mass for swelling tenderness and inflammation	1. Culture of purulent discharge in mouth 2. Hydration 3. Occlusal view xray of floor of mouth for calculi 4. Anti-Staphylococcal antibiotics: Augmentin, erythromycin	Otolaryngology-referral indicated for: 1. poor antibiotic response within one week of diagnosis - category 1- 2 2. caculi suspected on exam, xray, or U/sound – category 3. Abscess formation Category 1 4. Recurrent sialadenitis category 4 5. Hard mass present neoplasm? Category 2
Salivary Gland Mass	1. Complete head neck exam indicated 2. Evaluate facial nerve function with parotid lesions		**NOTE:** 20% of adult parotid masses are malignant & 50% of submandid glan masses are malignant Otolaryngology referral indicated in all cases of salivary glan tumours – category 2-3

NATIONAL REFERAL GUIDELINE : ORL, HNS			
Diagnosis	Evaluation	Treatment Options	Referral Guidelines
NASAL & SINUS General problems include: - Nasal congestion uni-or bilateral, on alternating - Nasal discharge uni- or bilateral - Diminished sense of smell & taste - Facial pain - Postnasal drip	These general symptoms may include any and all of the general or specific problems noted Thorough history and physical exam of the head and neck is required for determining the diagnosis as below	Specific treatments depend on the specific problem identified, as below	1. It problems resolve in less than three episodes 2. if the symptoms recur a third time resolve incompletely or persist specialty referral is indicated - category 4 – or earlier if severe
Specific problem include Epistaxis - persistent or recurrent	1. Determine whether bleeding is unilateral or bilateral 2. Determine whether bleeding is anterior or posterior 3. Determine is any bleeding diathesis or hypertension is present	Immediate control may occur with: 1. Pressure on the nostris (> 5 mins) 2. If bleeding is visible in littl's area consider cautery with silver nitrate (after applying topical anaesthesia) 3. Intransal packing coated with antibiotic ointment only it done by appropriate person with good equipment Afterwards – Vaseline or	Referral to an Otolaryngology is indicated if: 1. Bleeding is posterior – category 1-2 2. Bleeding persists -category 1 3. Bleeding recurs category 3

		bactroban for protective layer to prevent drying	
Persistent Nassal Obstruction	1. symptoms : nasal obstruction (uni/bilateral,alternating) postnasal discharge recurrent sinusitis 2. Physical examination requires intranasal examination after decongestion : deviated septum enlarged turbinates nasal polyps	Treat any associated allergy or sinusitis	Reter if simple measures fail – category 4 Otolaryngology referral is imperative if there is an offensive bloody discharge category 2. Note : in unilateral nasal obstruction with an oftensive bloody discharge: - in a child – consider a foreign body - in an adult – consider a malignancy)
Acute Viral Upper Respiratory Tract infection	1. Short duration, often sore throat at onset. 2. Nasal congestion 3. Clear nasal discharge. 4. May be associated with systemic viral symptoms	1. Systemic decongestants,anti-pyretics'supportive therapy,NB Antihistamines thicken secretions with possible adverse effects. 2.Topikal decongestant sprays may be used to a maximum of 5 days.	ENT referral not generally indicated unless sinusitis develops,see section on ''acute sinusitis''- Caregory 4.

NATIONAL REFERAL GUIDELINE : ORL, HNS			
Diagnosis	Evaluation	Treatment Options	Referral Guidelines
Acute Sinusitis	1. Unilateral or bilateral nasal congestion usually evolving from a viral URTI signs of sinusitis include: a) Purulent discharge b) Facial forehead or periorbital pain c) Dental pain d) persisting URTL > 7 days 2. History and physical examination may be non contributory 3. Sinus Xrays rarely indication	1. initial treatment: a) Broad spectrum antibiotic eg Amoxycillin rulide for 2 weeks b) Systemic decongestans antipyretics supportive therapy NB Antihistamines may cause adverse effects c) Topical decongestans sprays to a maximum of 5 days 2. Secondary treatment fails B-lactamase resistant antibiotic	Consider Otolaryngology referral indicated if: 1. Secondory antibiotic treatment fails clinically – category 3-4 2. Complication occur: Periobital cellulitis persistent trontal headache – category 1 3. Recurrent infections : over three episodes in a one year period – category 4
Chronic Sinusitis/Polyposis	1. Symptoms a) Persistent or recurrent nasal congestion (unilateral or bilateral) b) Postnasal discharge c) Epistaxis d) Recurrent Acute sinusitis e) Anterior tacial pain migraine, and cluster headache	1. Antibiotics 2. Nasal Decongestant sprays (5/7) 3. Topical stroid sprays 4. Consider short caurse of steroids (eg. 20mgs dally/2 weeks)	Consider Otolaryngology referral if symptoms persist Persisting obnormal symptoms obnormal tindings and/or obnormal radiographs warrant referral – category 4

	2. Physical examination requires intranasal examination after decongestion		In some cases an earlier appointment may be required Note : In unilateral nasal obstruction with an offensive bloody discharge: - in a child-consider a foreign body – consider 2 - in an adult – category 2
Facial Pain	May be an isolated symptom or may be associated with significant nasal congestion or discharge Potential relations to intranasal deformity sinus pathology dental pathology TMJ dysfunction altered V nerve function and skull base lesions	If there is evidence of acute sinusitis treat with appropriate antibiotics	Referral indicated for persisting facial pain may include dental and Otolaryngology opinions – category 3
Allergy Rhinitis/VMR	1. Symptoms – seasonal or perennial: a) Congestion esp alternating b) Wateray discharge c) Sneezing fits d) Watery eyes e) Itchy eyes and/or throat 2. Physical Examination: a) Boggy swollen bluish turbinates b) Allergy shiners c) Allergy “salute”	1. Avoidance 2. Skin test with view to desensitization 3. Topical steroid sprays 4. Antihistamines 5. Oral steroids up to 10/7 6. For acute cases consider 5 days nasal decongestans.	Consider Otolaryngology referral if symptoms do not respond to medical management – category 4

NATIONAL REFERRAL GUIDELINES : ORL, HNS			
DIAGNOSIS	**EVALUATION**	**TREATMENT OPTIONS**	**REFERRAL GUIDELINES**
Acute Nasal Fracture	1. Immediate changes : oedem, ecchymoses, epistaxis 2. Evaluate for septal fracture or septal haematoma. 3. Nasal Xrays unnecessary 4. Check for malar/maxilla# 5. Facial bone Xrays if suspect facial#	1. Early treatment : cool compression to reduce swelling. 2. Re-Evaluate at 3-4 days to ensure nose looks normal and it breathing is normal.	Immediate optolaryngology referral if acute septal haematoma (usually significant nasal obstruction) -category 1. Otolaryngology referral initiated now it there is a new external nasal detormity. Note : nasal fratures must be reduce < 2 weeks for best result.
Foreign Bodies	a) Acute : history alone for visible examination. b) Chronic : Persistent, offensive, unilateral nasal dischanrge in a hild.	Don't attempt removal unless experienced and with good equipment.	Urgent referral for removal -category 1. Otolaryngology referral for removal – category 2.
Ear- children			

Acute otitis Medis	1. Symtoms : Otalgia, hearing loss, aural discharge, fever. 2. Examination : inflamed tympanic membrane ™ bulging TM, desquamated epithelium on TM, middle ear effusion. *NB : a tender swollen ear canal usually indicates otitis externa rather than otitis media.* 3. Audio : Tympanogram may show B or C pattern (not required it 1 & 2 present).	1. Initial treatment : [consider with-holding Abs] a) Broad spectrum antibiotic, amoxicillin, co-trimoxazole. b) Analgesia : Paracetamol c) Topical nasal decongestants and in adult, systemic decongestants d) If there is associated allergy. Topical nasal steroid sprays could beconsidered 2. Secondary treatment : if primary treatment fails, try B-Lactamse resistant antibiotic, eg Augmentin.	1. Immediately if complications noted : mastoiditis, facial weakness, dizziness, meningitis – category 1. 2. Secondary antibiotic treatment fails to control acute symptoms – category 1-2.
Recurrent Acute Otitis Media with resolution between apisodes	Recurring episodes of OM which responds to medical management with clearance of the middle ear between episodes – A tympanograms.	Alternatives : 1. Antibiotic prophylais at the onset of each URTI : amoxicillin or Co-trimoxazole. 2. 4-6 monts antibiotic prophylaxis with amoxycillin or Co-trimaxazole	Consider Otolaryngology referral it : 1. Infections continue despite antibiotic prophylaxis (6+per year) category 3. 2. Middle ear afusion occurs and persist (see below) – category 3.

NATIONAL REFERRAL GUIDELINES : ORL, HNS			
DIAGNOSIS	**EVALUATION**	**TREATMENT OPTIONS**	**REFERRAL GUIDELINES**
Otitis Media with effusion "Glue Ear"	May have few or no symptoms, pneumatic otoscopy/tympanometry needed. 1. Symptoms : Otalgia, hearing loss, language delay 2. Examination may include : TM discoloured, thinned or retrached Bubbles behind TM, TM sluggish/retrached on pneumatic otoscopy. 3. Tymp may show effusion (type B) or –ve pressure (typeC).[all children] 4. Audio :child > 4years	Up to three course of systemi antibiotics (10+/7 each)and at leastone course of B-Lactamase resistant anti biotic : Augmentin. *NB : Therapy with decongestants, antihistamines and steroids have not been shown to be beneficial (unless there are associated allergies)*	Otolaryngology referral with : 1. Persistent hearing loss sufficient to interfere with development – category 3. 2. Effusion, TM retraction or –ve middle earpreassure persist more than 3 monts – category 3. 3. Significant language delay in presence of OME – category 3. 4. Uni lateral effusion take less priority – category 4 if referred.
Infected Ventilation Tube	1. Symptomps Aural discharge with possible otalgia Associated hearing loss	Initial Treatment Treatment with topical antibiotic/steroid drops suh as Sotradex. Consider systemic antibiotics suh as Amoxycillin if the discharge is profuse and/or there is failure of response to topical antibiotic treatment alone. Treatment must be given for at least one week.	Failure of two weeks of antibiotic treatment, either topical and oral to resolve the discharge – category 2.

Blocked Ventilation Tube.	Evaluation symtomps often asymptomatic and found at routine examination. There may be omplaint of otalgia or hearing loss or tinnitus in that ear. Examination – the ventilation tube can be seen in place either with the lumen filled with either wax of solidified mucous.	Five drops of Softradex to the affected ear repeated daily for up to two weeks. When drops are tested in the mouth, the tube is unbloked.	Consider referral if there is recurrent middle ear effusion or the hild is symptomatic with the blockage – category 3.
Post Ventilation Tube Management	It usual for three to be a single post operative to check within an ENT department following ventilation tub insertion. There is no need for regular assessment within theENT Department if the child is progressing well and asymptomatic	Referral to the ENT Department for post extrusion hek is desirable to confirm that the tympanic membrane I in a satisfactory condition and that there has not been reccurence of middle ear effusion.	Otolaryngology referral once ventilation tubes are seen to be extruded. Category 3.

NATIONAL REFERRAL GUIDELINES : ORL, HNS			
DIAGNOSIS	**EVALUATION**	**TREATMENT OPTIONS**	**REFERRAL GUIDELINES**
Foreign bodies	Usually visible it acute	Remove only if technically easy.	Tolaryngology referral especially children – Category 2.
EAR - INFECTIONS Chronic Suppurative Otitis Media	1. Symptoms ; Chronic discharge from the ear(s), hearing loss. 2. Examination : perforation of drim (especially attic or postero-superiorly granulation tissue and/or bleeding). 3. Complications suggested by : Postauricular swelling/abscess, facial palsy, vertigo, headache – refer category 1.	1. Aural toilet (not syringing). 2. Culture directed antibiotic therapy : systemic and copious aural drops (softradex). 3. Protet ear from water exposure.	Ontolaryngology referral indicated for persistent symptomps despite appropriate treatment – category 3-4. Associated symptoms suggest urgency needed – category 2.
Acute Otitis Externa	1. Symptoms : Otalgia, significant ear tenderness, swollen external aud canal +/- hearing loss. 2. Examination : Ear canal always tender, usually swollen. Often unable to see TM because of debris of canal oedema. 3. Swab for org./fungi *NB : fungi otitis externa may have a pad and spores visible.*	1. Topical treatments is optimal and systemic antibiotics alone are often insufficient when there is cellulitis around the canal. 2. Insertion of an expandable wick with topical antibacterial medication useful when the canal is narrowed. 3. In fungal OE, thorough cleaning of the canal is indicated,	Referral to an ontolaryngology when : 1. Canal is swollen shut and wick cannot be inserted – category 1. 2. Cerumen impaction complicating OE – category 3. 3. Unresponsive to initial course of a wick and

		plus topical antifungial therapy.(Kenacomb, Locorten-Vioform).	antibacterial drops- category 2. 4. Diabetics, immunosupressed and suspect malignancy on examination require urgent referral – category 1.
Otalgia without significant clinical findings in the ear canal or drum.	1. Symptoms : ear pain without tenderness or swelling. 2. Physical Examination : normal ear canal and TM. 3. Type A Tympanogram *NB : Mmastoiditis in the presence of a normal drum without previous infection is almost impossible.*	Requires a diagnosis and appropriate treatment. Possible aetiologies include : TMJ syndrome ; Neck dysfunction; referred pain from dental phatology, tonsil disease and head and neck malignancy ; particularly tonsil/ hypo[harmarynx/larynx.	Referral to an otolaryngologist indicated if pain persist an aetiology not identified – category 3.

NATIONAL REFERRAL GUIDELINES : ORL, HNS			
DIAGNOSIS	**EVALUATION**	**TREATMENT OPTIONS**	**REFERRAL GUIDELINES**
HEARING LOSS *Note : Do Not syringe an ear with a drum known to have perforated in the past or known to be abnormal.* *Use sofradex drops afterwards X 1 "stat" after all syringng.*			
Neonatal	At Risk Register : - Family history of hereditary SNHL - In utero infection, eg CMV. Rubella - Craniofacial anomalies, inci pinna - Birth weight < 1500g - Hyperbiliribinaemia needing transfusiontheraphy. - Exposure to Ototoxic drugs - Bacterial meningitis - Apgar < 5 at 1 min; < 7 at 5 min - Mechanical Ventilation > 4 days - Stigmata assoc with hearing loss.	ABR by a trained Audiologist is the optimal investigation at present.	All hospital should run a screening programme for at risk neonates and infants. Awareness of changes in approach to neonatal screening for hearing loss.
Bilateral, Symmetrical, in Adults	4. Symptoms : Diminished hearing any associated symptoms, eg tinnitus, discharge, vertigo, ect. *5.* Examination : cerumen, effusion, or normal findings.	a) Cerumen dissolving drops and possible suction or irrigation. b) Oral decongestant, Valsava manoeuvres and re- evaluate in three weeks. c) Requires audiometry +/- referral.	Referral indicated if : a) Ceerumen, and/or significant hearing loss persist – category 4. Urgent Otolaryngology referral if < 1 week for acute treatment – category 1. If onset less than 1 week refer.

Chronic	*4.* Symptoms : difficulty hearing esp. only in a crowded environment ; difficulty localizing sound. *5.* Examination : a) Cerumen b) Abnormaltympanic membrane.	Cerumen dissolving drops and possible suction or irrigation.	Otolaryngology referral if the ear has not been previously assessed by an otolaryngologist or the symptoms anf/or clinical findings have changed – category 4. NB : unilateral effusion in adults? Sinus disease or Nasophryngeal tumor (especially in Chinese)

NATIONAL REFERRAL GUIDELINES : ORL, HNS			
DIAGNOSIS	**EVALUATION**	**TREATMENT OPTIONS**	**REFERRAL GUIDELINES**
TINNITUS A. Chronic Bilateral	Any associated symptoms? Cerumen? Audio + Tymp	Clear cerumen and check TM. If TMS clear, no treatment.	No referral indicated unless tinnitus is disabling or associated with hearing loss, aural discharge or vertigo – category 3 – 4 depending on symptoms.
B. Unilateral or recent onset	Any associated symptoms? Cerumen? Audio + Tymp	Clear cerumen and check TMif symptoms persist refer.	Referral indicated especially if it is disaling, or associated with hearing loss, aural discharge or vertigo. Category 3 - 4
C. Pulsatile	TM normal or (vascular) mass behind drum. Audio + Tymp Auscultate carotid vessels	Referral	Referrals indicated in all cases- category 4. If there is a middle ear mass, there is a strong possibility of a glomus tumor. Category 2
DIZZINESS A. Sudden Onset Vertigo – Associated with Barotrauma	Acute onset of vertigo or disequilibrum associated with pressure change usually caused by air flight or driving. There may be associated hearing loss and tinnitus.	Possibility of a perilymph fistula between their inner ear and middle ear must be considered	This condition requires immediate referral for specialist management, Category 1.
B. orthostatic	Symtoms mild, brief and may only on standing up (usually am). Review medications	Evaluatecardiovascular system, reassurance	No referral indicated unless typical or associated with other symptoms and this should normally be Medical

C. BPV &Vestibular Neuronitis	Associated with an URTI, may be positional and/or persistent. Audio TM joint examination? Spontaneous nystagmus	Self limiting over a few monts. Symptomatic medication. Eg stemetil may help VN.	Referral with : Associated hearing loss, increased severity, persistence over 2 months- category 3.
D. Chronic or Episodic	Significant vertigo May have associated hearing loss, tinnitus, aural fullness, nausea. History of previous ear surgery Audio + Tymp	Symptomatic treatment acute	Otolaryngology referral is indicated – category 3-4, dependent on history
FACIAL PARALYSIS	Weakness of paralysis of movement of all (or some)of the face. Maybe associated with otalgia, otorrhoea, vesicle, parotid mass or tympanic membrane abnormality	Protection of the eye from a corneal abrasion is paramount. Lacrilube and taping the eye shut at night. Steroid therapy may be initiated if no associated clinical findings.	Urgent Otolaryngology referral is indicated it otologic cause suspected – category 1.

FAKULTAS KEDOKTERAN
UNISMUH MAKASSAR