



सत्यमेव जयते



# Common ENT Complaints For FLW





# COMMON ENT COMPLAINTS

## Nose

- Epistaxis (Nose Bleeds)
- Upper Respiratory Tract Infections
- Foreign Body In Nasal Cavity

## Ear

- Wax
- Furuncle
- Earache (Otalgia)
- Otitis Externa (External Ear Infection)
- Otitis Media (middle Ear Infection)
- Vertigo
- Hearing Loss/ Reduced Hearing
- Foreign Body In Ear

## Throat

- Ulcers
- Acute Tonsillitis
- Acute Epiglottitis
- Foreign Body In Air Passage



# Epistaxis (Nose Bleeds)





# EPISTAXIS (NOSE BLEEDS)

## Identification

- Common complaints especially during winters
- In the majority of cases, are self-limiting and spontaneous
- If recurrent, massive, or occurring in children, cause of concern

## Classification

- Anterior bleeds: Most common and relatively easier to control. Presents as bleeding from the nose.
- Posterior bleeds: Less common, cause profuse bleeding and more difficult to control. Presents as bleeding from mouth.

## Causes

- Local causes: finger nail trauma, inflammation, tumours
- Systemic causes: hypertension, liver disease, kidney disease, blood thinning drugs
- Idiopathic or reason unknown



# MANAGEMENT AT ASHA / MPW LEVEL AND INDICATIONS FOR REFERRAL



# Management at your level



a) Ask for the following: Duration of current episode, previous history of similar episodes, trauma, bleeding elsewhere in the body, chronic liver disease, any drug intake, family history, chronic alcohol intake. Note down the relevant details.

b) Examination:

- i. Examine the nasal cavity using a torch to locate the site of bleeding.
- ii. Record the Blood pressure since sudden rise in blood pressure can also cause nosebleeds.

c) Management of epistaxis:

Mild anterior epistaxis cases usually resolve with the primary care management. Moderate to massive anterior bleeding as well as posterior nasal bleeds must be referred to a facility with specialist.





- For mild bleed: Immediate relief can be obtained by tilting the head forward and pinching the nostrils together for 10 minutes. If it continues bleeding, pinch nostrils together for 10 more minutes.
- For moderate bleed: Refer the person to the SHC-HWC where you will assist the CHO in the following management.
  - Make sure the person is relaxed. Check whether the bleeding is anterior (bleeding from nose) or posterior(bleeding from mouth).
  - Make him/her sit upright with head slight bent forward.- Ask the patient not to blow through his nose.
  - Incase of anterior bleeds, apply pressure on the bleeding side of the nose for 10 mins.



- If bleeding doesn't stop, apply a combination of topical anesthetic, such as 2% lidocaine and vasoconstrictor and wait for 10 mins. Soak cotton balls in a mix of 2% lidocaine and 1:1000 epinephrine. Put 1-2 cotton balls into the bleeding nostril (If bleeding is not clearly unilateral, put cotton balls into both nostrils.) Place a dry cotton ball at the nostril opening to prevent leakage and dripping. Leave the cotton balls in place for 10 minutes.
- If the bleeding still doesn't stop, or in case of posterior bleeds, pack the nose and refer to higher center for appropriate care.
- Antibiotics may be given to prevent infection (sinusitis) if pack is to be kept beyond 24 hours.
- If bleeding is severe or the person is unconscious, call an ambulance and refer immediately to the District Hospital where ENT surgeon is available.





# INDICATIONS FOR REFERRAL



1. High BP at presentation
2. Epistaxis not controlled with high local pressure for over 20 minutes
3. Massive blood loss
4. Bleeding following trauma to the face, with suspected facial fractures
5. Other co-morbidities requiring appropriate cross consultations
6. For posterior nasal packing in case of posterior epistaxis





# MPW/ ANM RESPONSIBILITIES IN MANAGING NOSE BLEEDS



- Administrator first aid for any case of nose bleeds brought to the center
- Check for high blood pressure or any other injury
- If the nose bleed does not stop after 15 minutes, support CHO to refer to higher center
- Follow up all cases that are referred or treated
- During health education, focus on awareness of how to prevent nose bleeds by avoiding picking of the nose and use Vaseline during summer and dry season
- Keep records of all cases and report on a monthly basis to the PHC





# Upper Respiratory Tract Infections (URIS)





# UPPER RESPIRATORY TRACT INFECTIONS (URIS)

## Identification

- URIs are most common, especially amongst children.
- Majority are viral infections, use of antibiotics is usually not recommended and symptom-based treatment is practiced.
- Certain conditions may need antibiotics- pneumonia, throat abscess, etc.

## Classification

- Sinusitis
- Rhinitis –
  - viral (common cold)
  - allergic
  - atrophic
- Pharyngitis
- Tonsillitis (Throat problem)

## Causes

- Local causes: fingernail trauma, inflammation, tumors
- Systemic causes: hypertension, liver disease, kidney disease, blood-thinning drugs
- Idiopathic or reason unknown



# CLINICAL FEATURES - URIS

## SINUSITIS

- Facial pain or sinus pain
- Purulent nasal drainage
- Fever
- Stuffy / blocked nose

## PHARYNGITIS

- Sudden onset of sore throat
- Pain in throat
- Fever, malaise.

## RHINITIS

- Simple viral : Watery nasal discharge; Watering from eyes; Nasal stuffiness; Malaise, fever and headache
- Allergic : Frequent bouts of sneezing; Itching of nose, eyes, ears, palate; Watery nasal discharge; Blockage of nose; Watering from eyes with redness & itching.
- Atrophic : Greenish crusts present in nasal cavity; Foul smell from nose and patient not aware of it; Nasal blockage, roomy nasal cavity, nasal deformity, history of maggots.



# MANAGEMENT AT ASHA / MPW LEVEL AND INDICATIONS FOR REFERRAL



# Management at your level



Most cases of rhinitis and pharyngitis are viral and will need only symptomatic treatment, if any. You should counsel the patient about the following for treatment and prevention of these diseases.

1. Drink plenty of water and get enough rest.
2. Sniff a little salt water into the nose, or breathe steam from hot water to clear the nose.
3. No special diet is needed. However, eating oranges, tomatoes, and other fruit containing vitamin C may help.
4. Do not take antibiotics if not prescribed.
5. Contrary to popular belief, colds do not come from getting cold or wet (although getting very cold, wet, or tired can make a cold worse). A cold is 'caught' from others who have the infection and sneeze the virus into the air.





6. To keep from giving his cold to others, the sick person should eat and sleep separately—and take special care to keep far away from small babies. He should cover his nose and mouth when he coughs or sneezes, and wash his hands often if possible.

7. Simple medicine such as Paracetamol helps lower temperature and relieves body aches and headaches. More expensive ‘cold tablets’ are no better.

8. Wipe a runny or stuffy nose, but try not to blow it. Blowing the nose may lead to earache and sinus infections.

Note: If complain of facial pain/ sinus pain is lasting for more than 3 months than it is known as chronic sinusitis, for which you have to refer the patient to higher center for further management and treatment. Follow-up is the important key here.







# MPW/ ANM RESPONSIBILITIES IN MANAGING URIs



- Identify the type of URI when the patient comes to the clinic or you see a case in the field
- Provide general symptomatic treatment for the fever, runny nose, and headache
- Advise rest, steam inhalation, drinking warm fluids, and good nutrition
- If suspecting a bacterial infection, inform the CJO who will refer to the MO to initiate antibiotics. Once prescribed, you can ensure that the patient gets and takes the antibiotics correctly and completes the course.
- Follow up on all cases treated with antibiotics and all chronic cases
- Conduct health education sessions to prevent colds and raise immunity through good nutrition and regular health check-ups
- Keep updated records





# 3. Acute Tonsillitis





# ACUTE TONSILLITIS



## IDENTIFICATION

- Tonsils are a pair of special tissues situated at the back of the throat.
- Often, especially in children, get infected and inflamed

## SYMPTOMS

- Sore throat
- Difficult or painful swallowing
- Fever
- Earache
- Change in voice
- General symptoms like headache, bodyache etc.

## SIGNS

- Red and swollen tonsils
- May be studded with follicles or membrane. (White or yellow coating or patches on the tonsils)
- Enlarged, tender glands (lymph nodes) in the neck



# MANAGEMENT AT ASHA / MPW LEVEL AND INDICATIONS FOR REFERRAL



# Management at your level



Most of the cases with tonsillitis can be managed by medicines alone. The usual line of treatment in uncomplicated cases includes:

1. Tab. PCM
2. Antibiotics like Amoxicillin (which can only be prescribed by a doctor)
3. Warm Saline Gargles / Betadine gargles, 3-4 times a day

Some patients may need to undergo surgery for cure: repeated infection of throat (7 or more episode sin 1 year or 5 episodes per year for 2 years or 3 episodes per year for 3 years), or if the swollen tonsils cause airway obstruction, difficulty in swallowing/speaking and cases who do not respond with antibiotics.





# MPW/ANM RESPONSIBILITIES IN MANAGING ACUTE TONSILLITIS

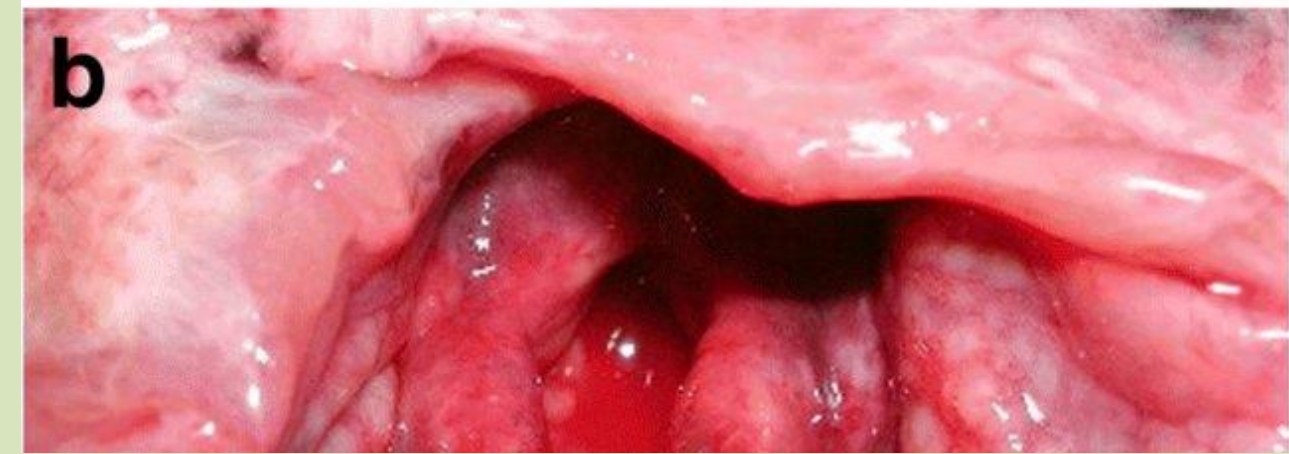
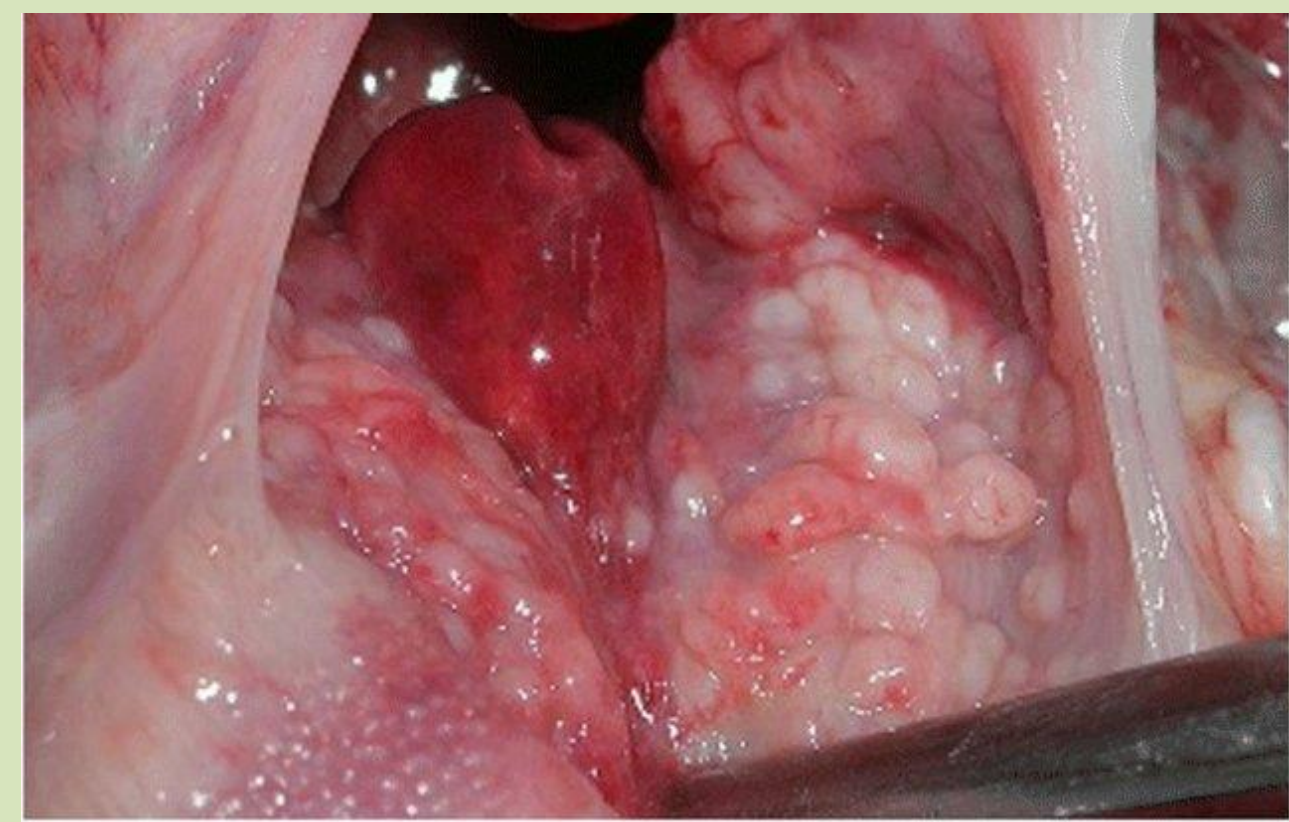


- Check the throat of all those who complain of sore throat or difficulty in swallowing.
- Advise hot saline water gargles and avoiding any cold, oily or spicy foods.
- If tonsils are inflamed or there is an exudate. the patient will require antibiotics, inform the CHO who will refer the patient to the MO-PHC to initiate antibiotics.
- Ensure that the patient is taking the full course of antibiotics and other medicines prescribed.
- Follow up all cases. If there is no improvement in a week, then inform CHO and refer the case back to higher centers where there is an ENT specialist.
- During health education sessions, emphasize on importance of avoiding dust, keeping the throat moist by sipping water often and maintaining good personal hygiene.





# 4. Acute Epiglottitis





# EPIGLOTTITIS



## IDENTIFICATION

- Very serious/dangerous condition which mostly affects children 2-7 years of age.
- Caused by bacterial infection of the lower airway (larynx)
- Cause airway to swell up and leads to obstruction and difficulty in breathing

## CLINICAL FEATURES

- Sudden onset of symptoms
- Difficulty in breathing
- Noisy breathing
- Very high fever
- Sore throat and difficulty in eating (in adults)





# MANAGEMENT AT ASHA / MPW LEVEL AND INDICATIONS FOR REFERRAL



# Management at your level

Children with this infection must be hospitalized because there is danger of respiratory obstruction and death. The child might be unable to swallow so intravenous fluids and antibiotics have to be started urgently. Immediately inform the CHO who will refer the child to a higher center where ENT specialist or pediatrician is available.



# MPW/ANM RESPONSIBILITIES IN MANAGING ACUTE EPIGLOTTITIS



- If you see a child with breathlessness, noisy breathing and fever, immediately inform the CHO who will refer the patient to an ENT specialist to initiate treatment.
- Follow up the child once he/she returns from the facility to ensure that he/she is taking the full course of antibiotics and other medicines prescribed.
- Follow up all cases. If there is no improvement in a week, then inform CHO and refer the case back to higher centers where there is an ENT specialist.
- During health education sessions, emphasize on maintaining good personal hygiene.
- Pentavalent vaccine (given at 6, 10 and 14 weeks of age) is protective against this disease. Ensure that all children are fully immunized.
- Keep records of all cases updated.





# GROUP ACTIVITY

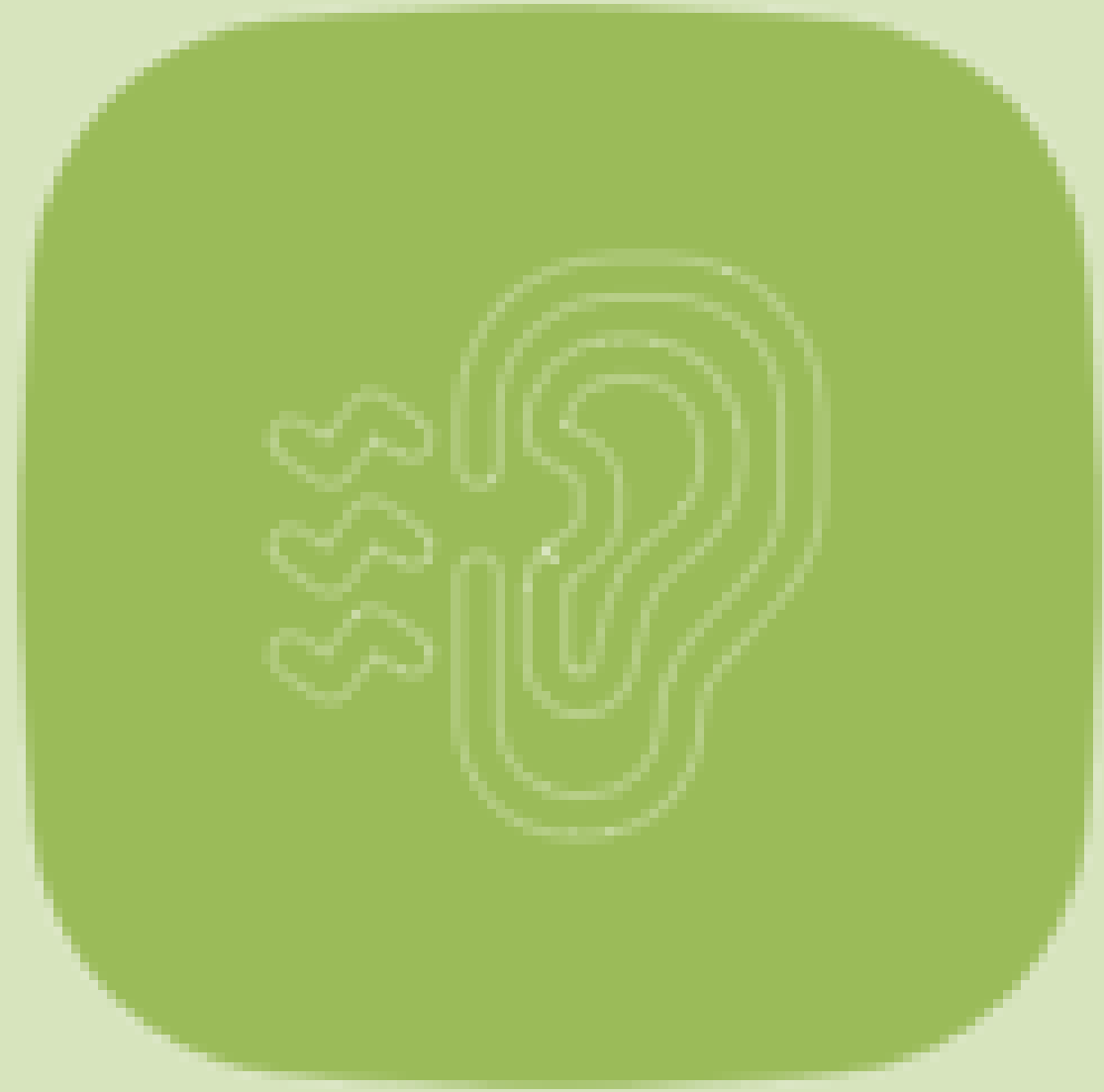


- Divide the participants into 5 groups
- Each group will be given 1 ENT complaint
  - Group 1 –EARACHE (OTALGIA)
  - Group 2 – OTITIS EXTERNA (EXTERNAL EAR INFECTION)
  - Group 3 – OTITIS MEDIA (MIDDLE EAR INFECTION)
  - Group 4 – VERTIGO
  - Group 5 – HEARING LOSS/ REDUCED HEARING
- Groups have to discuss ENT related conditions including–
  - Identification /Types
  - Risk factors /Causes /spread
  - Signs & Symptoms
  - Treatment & prevention (Management); Referral
  - Role of ASHA / MPW
- Participants from each group will present

**Time:  
15 min**



# 5. Ear ache (Otalgia)





# EPIGLOTTITIS



## IDENTIFICATION

- Pain in the ear is known as Otolgia. It is a symptom.
- It is essential to find its cause before specific treatment can be instituted.
- Most commonly presents in childhood; may occur in adults.

## CLINICAL FEATURES

### Primary otalgia (most common)

- Pain exists within the ear itself.

### Secondary (referred) otalgia:

- Ear is innervated by many nerves, cranial nerves number V, VII, IX and X.
- Any abnormal stimulation of any branch of the above mentioned nerves leads to pain in ear. E.g. problems in the teeth, jaw, etc.



# MANAGEMENT AT ASHA / MPW LEVEL AND INDICATIONS FOR REFERRAL



# Management at your level

Refer any case of earache to the CHO at SHC-HWC and assist the CHO in the following management:

- Carry out a thorough general and systemic examination, including ear, oral and throat examination.
- It is important to find out the underlying cause before starting any specific treatment.
- Look for signs of infection/ trauma around the ear.





- If there are secretions in the ear canal. mop them clean with a sterile gauze piece.
- Instill antibiotic ear drops such as Ciprofloxacin ear drops, 2 drops at a time, 2-3 times a day only when no discharge is coming out from ear. In case of active discharge, the possibility of ear perforation may be there, so keep the ear dry.
- For reducing pain, start Paracetamol 25-30 mg/kg/d in three divided doses.
- Follow up after 5 days to assess response to treatment.

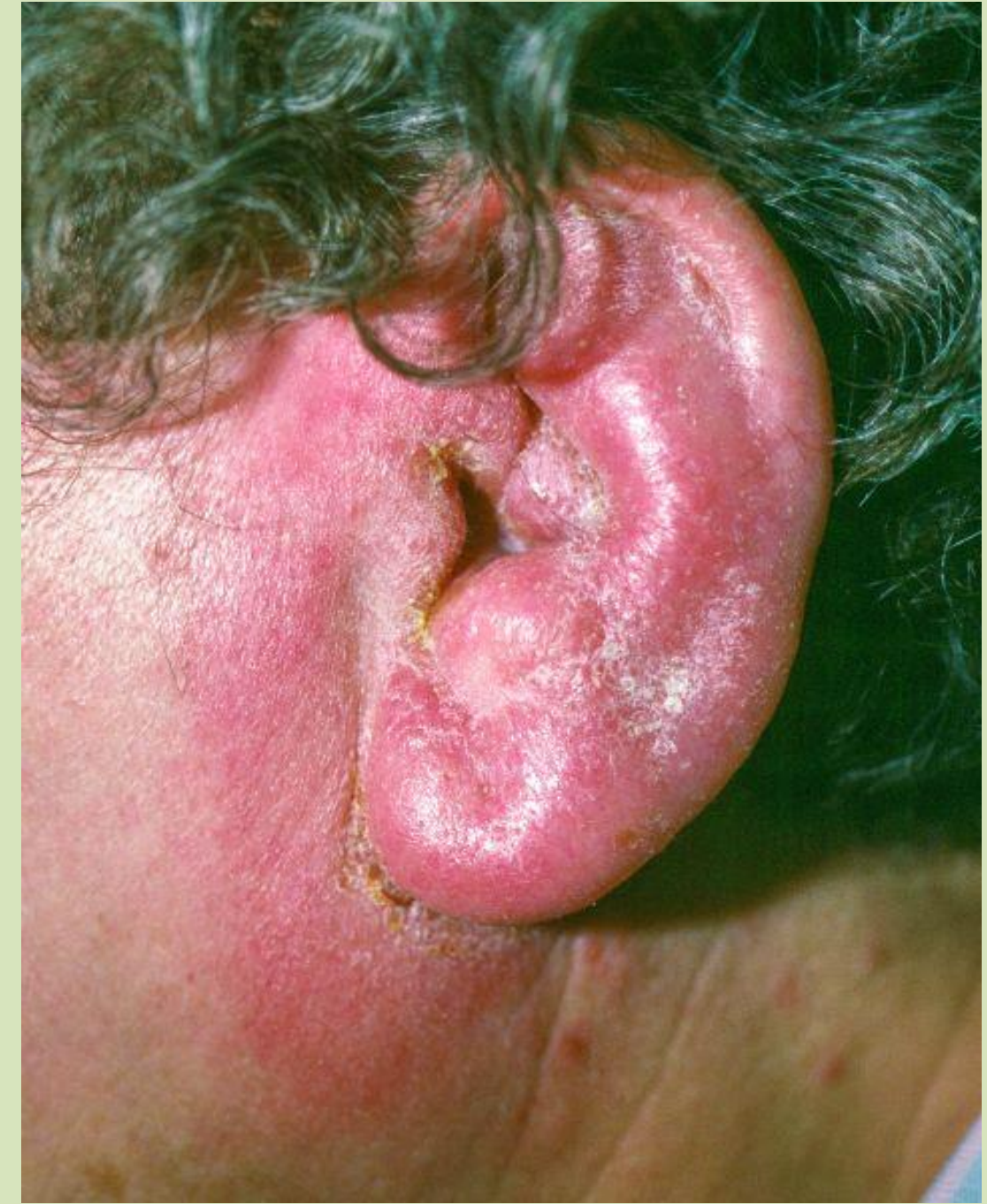


# Indications for referral to ENT specialist

- Any severe acute pain needs referral after giving painkillers.
- Chronic pain (ie. pain lasting >2 weeks), especially if associated with other head/neck symptoms.
- Swelling/ other signs of inflammation at external auditory canal.
- Patient having high grade fever/ appearing toxic.
- Earache following trauma.
- When no apparent reason for earache can be found even after thorough history taking and examination.



# 6. Otitis Externa (External Ear Infection)





# OTITIS EXTERNA (EXTERNAL EAR INFECTION)



## IDENTIFICATION

- Inflammatory process of the external ear canal.
- Caused by infection (usually bacterial, occasionally fungal)
- May be due to non-infectious systemic or local dermatologic processes.

## RISK FACTORS

- Ear canal is warm, dark and prone to becoming moist; environment for bacterial and fungal growth
- Canal is easily traumatized in injuries.
- Curve in the canal; anything that goes inside is difficult to come out.
- Hair in ear can lead to infected boils.

## CLINICAL FEATURES

- Severe pain on movement of pinna.
- Jaw movements painful.
- Swelling of lymph nodes around the neck
- Diffuse inflammation of ear canal with crusts and discharge



# MANAGEMENT AT ASHA / MPW LEVEL AND INDICATIONS FOR REFERRAL



# Management at your level

- i. Clean ear with a dry cotton wick.
- ii. An ear pack of 10% ichthammol glycerin provides relief and reduces pain. (Hygroscopic action of glycerin reduces oedema, while ichthammol is mildly antiseptic)
- iii. Cap Amoxicillin for 5 days in age appropriate dosage (can only be prescribed by a doctor- the CHO will consult the MO-PHC for antibiotics)
- iv. Tab Paracetamol 500 mg twice daily for days.



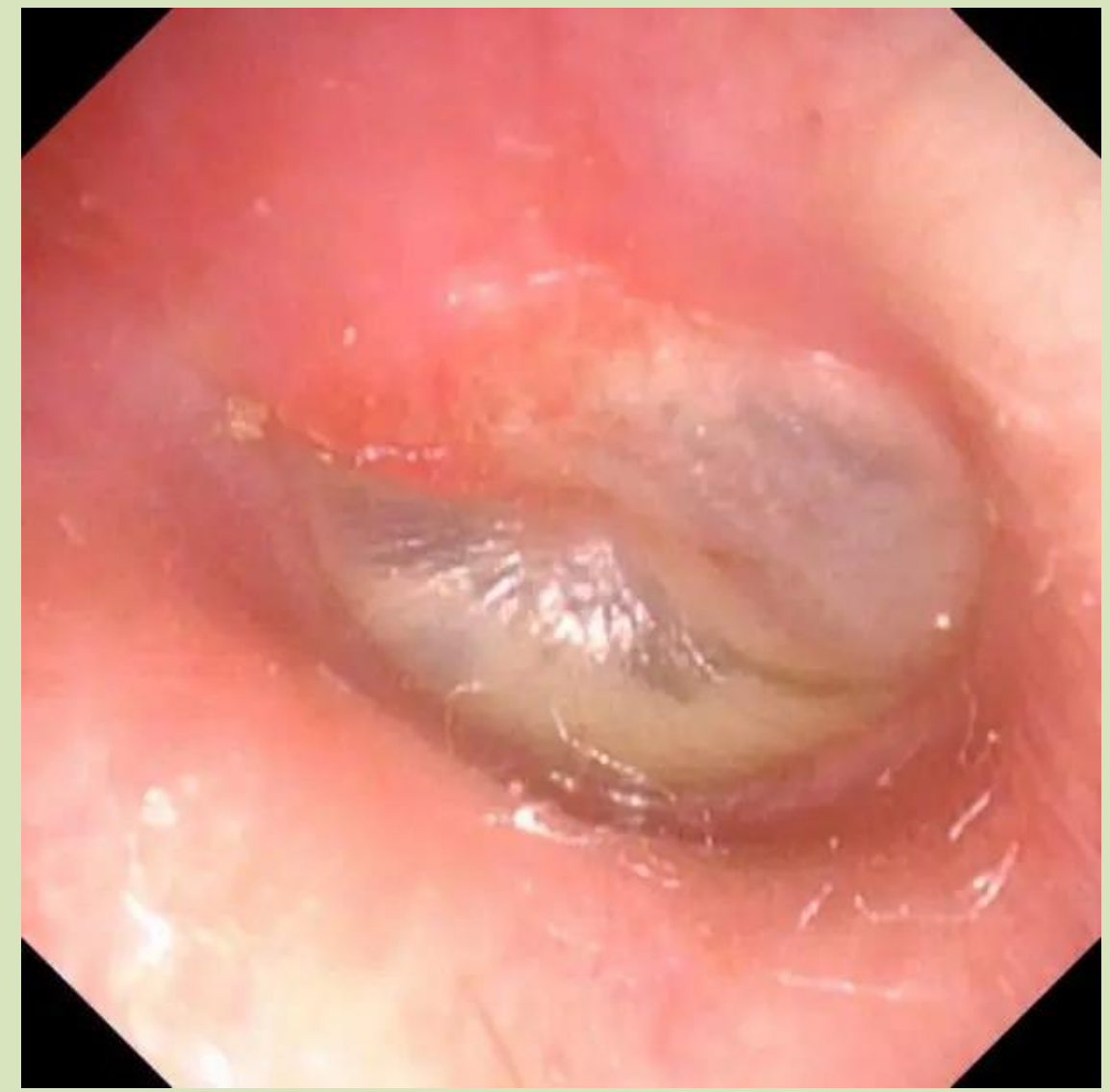
## MPW/ANM RESPONSIBILITIES IN MANAGING EXTERNAL EAR INFECTION

- Diagnose all cases of ear pain and confirm infection of the outer ear canal.
- Clean ear with a dry cotton wick.
- Give symptomatic treatment for pain.
- Inform the CHO who will consult with the MO-PHC or ENT specialist for confirming diagnosis and initiating treatment.
- Follow up all cases to ensure that they complete the antibiotic treatment. In case there is no improvement after 1 week, inform the CHO who will refer back the case to the ENT specialist.
- Maintain updated records.
- Advise the community about maintaining personal hygiene and how to clean the ear regularly.
- Also advise to avoid putting sharp objects in the ear. Clean and dry the ear after swimming.





# 7. Otitis Media (middle Ear Infection)







# OTITIS MEDIA (MIDDLE EAR INFECTION)

## INTRODUCTION

- Inflammatory condition of the middle ear
- Most commonly presents in infants and children; may be in adults.
- Poor hygiene is commonly associated

## CLASSIFICATION

- Acute Suppurative Otitis Media: acute bacterial infection of the middle ear
- Chronic Suppurative Otitis Media: Result of long-standing infection of the middle ear



# OTITIS EXTERNA (MIDDLE EAR INFECTION)



## RISK FACTORS

- Recurrent attacks of cold and URIs
- Diseases like measles, diphtheria, whooping cough
- Infections of tonsils
- Chronic rhinitis and sinusitis
- Nasal allergy
- Cleft palate

## SYMPTOMS

- Earache – even disturbs sleep
- Reduced hearing
- High fever
- If ear drum is perforated:  
Bleeding / pus ear discharge
- Tinnitus (ringing sound in the ear)
- Additional symptoms in children – fever / vomiting / loose motion / sleeplessness / cry / irritability

## SIGNS

- Signs of URIs
- Tenderness present over mastoid region (bony part behind the ear lobe)
- External auditory canal may contain blood-tinged discharge / pus



# MANAGEMENT AT ASHA / MPW LEVEL AND INDICATIONS FOR REFERRAL



# Management at your level



If you suspect Otitis Media, immediately refer the patient to the CHO and assist in the following management:

- Counsel the patient about:
  - Keep the ear dry (prevent water from getting into the ear).
  - In case of discharge – dry mopping of the ear with a clean cotton wick.
  - No putting any ear drops or oil into the ear.
- Dry mopping of the of the ear canal with sterile cotton wick.
- Tab. Paracetamol(500 mg) three times a day OR Syrup Paracetamol 10–15mg/kg body weight in 3 divided doses (Pediatric).





# Management at your level



- Antibiotics like Amoxicillin or Azithromycin for 5–7 days (can only be prescribed by a doctor—the CHO will consult the MO–PHC for antibiotics)
- Nose drops (1% in adults and 0.5% in children or Xylometazoline or oxymetazoline can be used 2–3 drops thrice a day) to reduce nasal blockage. This can improve symptoms.
- Ear toilet: If discharge is present, then a sterile cotton can be used to mopped it but care to betaken not to put cotton roll inside, only discharging pus needs to be cleaned.
- Dry local heat: it also helps to relieve pain. Take a small hand towel, dip in hot water, and place over ear lobe.





# When to refer to a specialist

- No improvement or symptoms worsen even after 48 hours medical treatment.
- Patient develops features like vomiting with headache/facial palsy/dizziness/mastoid tenderness.
- Any other condition is also present such as tonsillitis, rhinosinusitis.
- If foul smelling discharge is present.





# MPW/ ANM RESPONSIBILITIES IN MANAGING MILD EAR INFECTION



- Diagnose all cases of ear pain and fever, confirm infection of the middle ear
- Clean ear with dry cotton wick
- Give symptomatic treatment for pain
- Inform the CHO who will consult with the MO- PHC or ENT specialist for confirming the diagnosis and initiating treatment
- Follow up on all cases to ensure that they complete the antibiotic treatment. In case there is no improvement after 1 week, inform the CHO who will refer back the case to the ENT specialist





- Maintain updated records
- Advise the community about maintaining personal hygiene and how to clean the ear regularly
- Also, advise avoiding putting sharp objects in the ear. Clean and dry the ear after swimming
- Ensure that all children in your area are fully immunized





# 8. Vertigo





# Vertigo



- Subjective feeling of movement, either of self or the objects around in the environment.
- Various terms are used by patients - bouncing, oscillating, twisting, rolling, spinning, light-headedness, imbalance, floating, fainting, etc.
- Different from dizziness (occurs due to low BP or weakness).
- Inner ear is responsible for carrying sound and also for maintaining balance. Any disease of the inner ear therefore causes a feeling of disbalance.
- Treated with specific medicines, but sometimes the underlying cause can also be a tumor (benign or malignant) in the inner ear or in the brain.



# CLINICAL FEATURES - VERTIGO

The patient complains of:

- Dizziness , increased on change in position
- Feeling of rotation or spinning
- Light headedness, faintness, weakness
- Associated with blurring of vision, syncope or 'blacking out' and imbalance/ unsteadiness





# MANAGEMENT AT ASHA / MPW LEVEL AND INDICATIONS FOR REFERRAL



# Management at your level



- Inform the CHO immediately. The patient will usually require to be assessed by an ENT specialist.
- Reassure regarding the nature of the disease avoiding the posture that triggers the symptoms.
- Counsel the patient about:
  - Reduced intake of caffeine alcohol.
  - Avoiding performing tasks which may cause harm to patient such as working on heavy machines, driving, etc.





- Keep a note of the medicines being consumed and emergency contact numbers in your pocket whenever going out of house alone.
- Follow up with the patient once back from the referral facility to ensure compliance to any medicine and any other instructions given by the ENT Specialist.
- Exercises are helpful in regaining the balance and confidence of the patient. It is to be done only if advised by the Specialist.



# MPW/ANM RESPONSIBILITIES IN MANAGING VERTIGO



- Inform the CHO who will consult with the MO-PHC and refer the patient to an ENT specialist for confirming diagnosis and initiating treatment.
- Follow up all cases to ensure that they complete the prescribed treatment. In case there is no improvement after 1 week, inform the CHO who will refer back the case to the ENT specialist.
- Maintain updated records.
- Support the patient for any lifestyle modification or exercise that may have been prescribed by the Specialist.





# 9. Hearing Loss/ Reduced Hearing







# HEARING LOSS/ REDUCED HEARING

- Reduced hearing or loss of hearing (deafness) is a condition where the person is not able to hear anything or can hear only loud sounds.
- Hearing loss may affect people of any age group.
- Some babies are born with congenital deafness which happen when the mother is exposed to certain infections, medicines or radiation during pregnancy.
- Old they slowly lose their hearing due to physiological ageing process and this is called presbycusis.





# HEARING LOSS/ REDUCED HEARING



- Complete or partial hearing loss due to-
  - Injury causing rupture of the eardrum
  - severe infection of the ear
  - Tumor in the ear
  - Sudden exposure to very loud sounds (like explosions)
  - Prolonged exposure to loud sounds (like people working in factories with noise from heavy machinery)
- Hearing loss can be of three types:
  - Conductive hearing loss (CHL) – middle ear problem
  - Sensorineural hearing loss (SNHL) – ear nerve problem
  - Mixed type



# HEARING LOSS/ REDUCED HEARING



- Untreated hearing loss affects communication
- Contribute to social isolation and loss of autonomy
- Not being able to hear properly is often associated with anxiety, and depression
- Hearing loss in children can affect their growing up, education, interaction with others and personality development
- Hearing loss in old age can impair their quality of life





# MANAGEMENT AT ASHA /MPW LEVEL AND INDICATIONS FOR REFERRAL



# Management at your level



It is very important to identify the people with hearing loss in the community and refer them to the CHO at the SHC-HWC.

At the sub center HWC level, it is important to have a good history of hearing loss. Some of the questions that should be asked and answered are:

- a) Onset of hearing loss — from birth or later
- b) Hearing loss happened suddenly or gradually
- c) Hearing loss is stationary or progressive
- d) Any family history of hearing loss
- e) Any other ear symptoms
- f) Any tests done earlier or treatment done.





Since most of the diagnosis and treatment requires a specialist, the CHO and team can only identify that there is some loss, and refer the client to the center where there is an ENT specialist.

Before referring the person, you can check for the following:

- 1) Any obstruction in the ear canal – foreign body, wax. etc.
- 2) Any ear discharge or recent history of injury to the ear.
- 3) Whether speech is affected also or not
- 4) If the hearing is lost for low frequency sounds or high frequency sounds
- 5) Any history of taking certain drugs recently
- 6) Exposure to very loud sounds – explosion, gun fire



# 10. Foreign Body In Ear





# FOREIGN BODY IN EAR

- Relatively common. Usually children insert small objects such as small toys, beads, stones and biologic materials such as insects or seeds into their ear
- Classification of Foreign bodies
  - Living: Insect, Flies, Maggots
  - Non-living:
    - Hygroscopic (can expand in moisture): e.g. vegetable, beans and seeds
    - Non-hygroscopic: e.g. beads, stones, pebbles, rubber, metallic object







# FOREIGN BODY IN EAR

- **Management at ASHA/MPW level**

- If superficial, visible and not a sharp object, you may attempt to remove it. Otherwise to the CHO at the SHC-HWC

- **Method of removing foreign body depends on its type**

Type of foreign body	What to use to remove
Soft and irregular like a piece of paper, swab or a piece of sponge	Fine alligator forceps
Smooth objects like seed grains, metallic objects	Syringing
Insect	Kill the insect with mineral oil or lidocaine Then remove dead insect with forceps
Sharp Object	Refer to the ENT specialist for removal



# FOREIGN BODY IN EAR



## When to refer to an ENT specialist

- Small child who cannot stay in one position to attempt removal
- Sharp objects
- Objects appear deep in ear canal
- Object appears to be tightly impacted
- Any kind of discharge from the ear
- Previous removal attempt was unsuccessful





# 11. Foreign Body In Nasal Cavity





# FOREIGN BODY IN NASAL CAVITY



- Foreign object may enter the nose either accidentally, or children may insert objects into their nose.
- If object is hygroscopic (eg. vegetable or seed), it swells up and cause difficulty in breathing; may even be aspirated into the airway.

## Clinical Features

- History of foreign body entering the nose
- Pain in nose
- Difficulty in breathing
- Discomfort and watering of nose and eyes





# FOREIGN BODY IN NASAL CAVITY

## Management at ASHA/MPW level

- If superficial, visible and not a sharp object, attempt to remove it. Otherwise refer to CHO at the SHC-HWC
- Forceps may be used to remove the foreign body at the SHC-HWC.
- If patient is breathless and gasping, call an ambulance and urgently refer to an ENT specialist

## When to refer to an ENT specialist

- Small child who cannot stay in one position to attempt removal
- Sharp objects
- Objects appear deep in nasal cavity or tightly impacted
- Any kind of discharge from the nose
- Previous removal attempt was unsuccessful



# 12. Foreign Body In Air Passage





# FOREIGN BODY IN AIR PASSAGE



## Clinical Features

- Foreign body in back of throat: choking, gagging and wheezing. May be coughed out /may lodge in the larynx.
- Foreign body in voice box (larynx): discomfort, pain in throat, hoarseness of voice, cough, and difficulty in breathing, wheezing and coughing blood.
- Foreign body in upper tube (Tracheal): Sharp object will produce cough and hemoptysis (blood in sputum).

## Management

- Keep coughing , If able to cough forcefully.
- If choking and can't talk, cry or laugh forcefully
- "Five-and-Five" approach to delivering first aid (American Red Cross )
- Give 5 back blows
- Give 5 abdominal thrusts.
- Alternate between 5 blows and 5 thrusts until the blockage is dislodged.

## When to Refer

- If above all methods fail
- If patient is turning blue (cyanosis)
- If patient become unconscious.
- If suspected foreign body is poisonous
- If patient require immediate investigation (like X-ray) to locate the position of the object

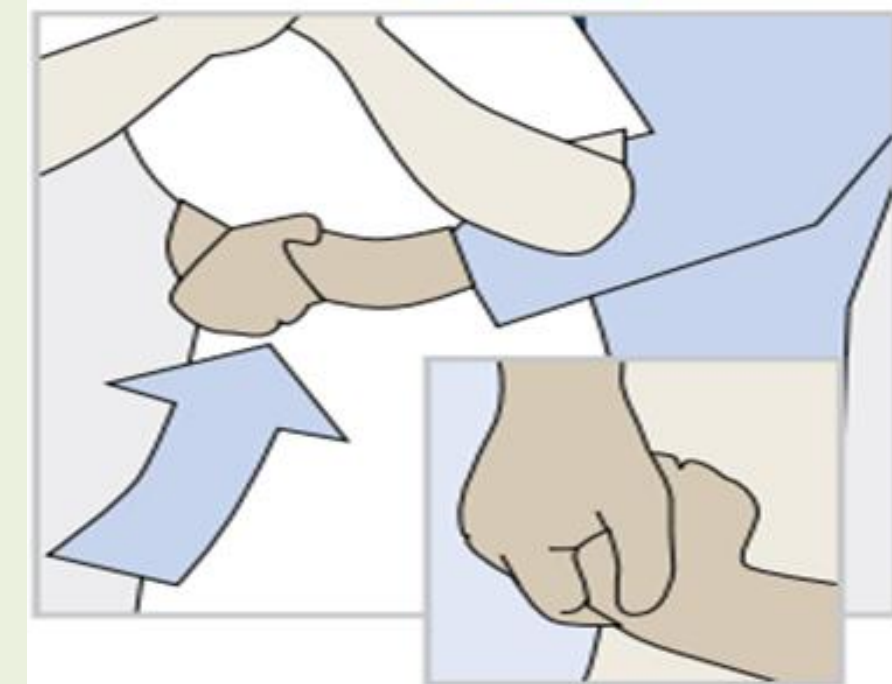




# FIVE-AND-FIVE APPROACH (FIRST AID FOR CHOKING)



- Stand to the side and just behind a choking adult. For a child, kneel down behind.
- Place one arm across the person's chest for support.
- Bend the person over at the waist so that the upper body is parallel with the ground.
- Give 5 separate back blows between the person's shoulder blades with the heel of your hand.
- Give 5 abdominal thrusts (Heimlich manoeuvre – page 15 ASHA Module)
- Alternate between 5 blows and 5 thrusts until the blockage is dislodged.







# 13. & 14. Wax And Furuncle



# FOREIGN BODY IN AIR PASSAGE



## WAX

- Very common; Secretion harden after contact with dust
- Decreased hearing, blocking of ear with pain, if amount increases or gets hard
- Managed by putting Sodium bicarbonate ear drops (2-3 drops) thrice daily for 4 days; soften wax.
- Tab Paracetamol for the pain
- Once wax is soft, clean with the cotton wick. Do not use ear buds.
- If wax does not come out, then refer the person to the SHC-HWC

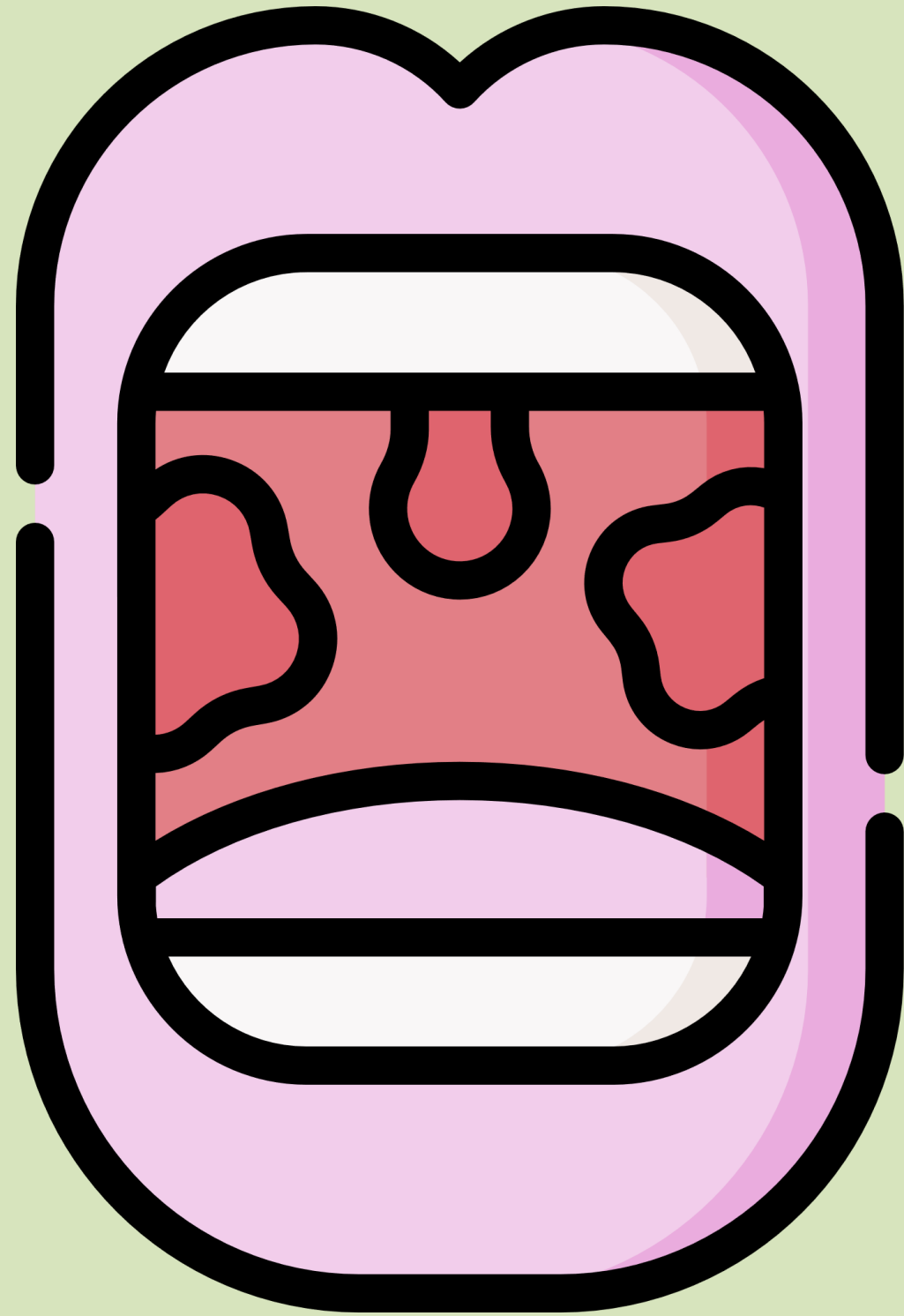
## FURUNCLE

- Small boil in ear canal
- Pulling the earlobe outwards causes pain
- Bursting of the boil may lead to pus discharge
- Managed by Cap Amoxicillin 500mg thrice daily for 5 days (if prescribed by doctor).
- Tab Paracetamol 500 mg thrice daily for 5 days.





# 15. Ulcers





# ULCERS



## SIGNS AND SYMPTOMS

- Very painful condition; small whitish wounds in the cheek or on the tongue
- Causes a lot of pain and difficulty in swallowing and eating.
- Ulcers usually heal on their own in 5-7 days

## MANAGEMENT

(in consultation with ANM/CHO)

- Advise people to avoid chewing beetle nut/tobacco /lime.
- Reassure that it usually disappears after few days and need no treatment
- Tell to use Chlorhexidine mouth wash 2-3 times a day and Tab Vit B-complex 1 tab daily for a week.
- Refer to the SHC- HWC if pain does not go away after a couple of days



# EVALUATION



1. Give examples of any 2 types of URIs?
2. An inflammatory condition of the middle ear space is known as?
3. ----- is a subjective feeling of movement, either of self or the objects around in the environment.
4. ----- approach is used to deliver first aid to the person in case of choking.
5. ----- can cause reduction in hearing and a feeling of discomfort/pain.



# EVALUATION



1. Give examples of any 2 types of URIs?

Sinusitis, Rhinitis & Pharyngitis

2. An inflammatory condition of the middle ear space is known as?

Otitis Media

3. ----- is a subjective feeling of movement, either of self or the objects around in the environment.

Vertigo

4. ----- approach is used to deliver first aid to the person in case of choking.

Five – and – Five

5. ----- can cause reduction in hearing and a feeling of discomfort/pain.

Ear Wax



सत्यमेव जयते



# Thank You

