PRACTICE OBSERVED

Emergencies in the Home

ENT emergencies in general practice

H DE LA HAYE DAVIES

The amount a general practitioner can do in managing ear, nose, and throat (ENT) emergencies depends on his experience and the availability of the right equipment. Ideally if he has experience in an ENT house job or as a clinical assistant then he will be expert in using the head mirror, a technique which requires some practice and which leaves his hands free to carry out various manipulations with his instruments. These manipulations are performed in dark, deep cavities or sensitive areas in patients who are usually frightened and liable to move at the slightest touch. Good illumination is therefore essential and, if one is not adept at using a head mirror, an electrically operated head lamp can provide a good source of illumination and at the same time leave both hands free. Most family doctors, however, are equipped only with the ordinary operating otoscope, which can if used properly provide quite good illumination for looking down ears and can also double up as a nasal speculum (in a child a perfect view can be obtained if the tip of the nose is just lifted and there is no necessity to insert a speculum). The light can also be used to visualise the pharynx and—with special attachments—the postnasal space and the larynx.

The experienced ENT doctor will probably also have his surgery equipped with Jobson Horne probes, wax hooks, aural forceps, nasal speculums, etc, which will enable him to carry out some of the procedures normally carried out in the ENT department. Whether two or expert, however, the golden rule is never to attempt anything unless you have not only the correct equipment but also the experience and confidence that you will succeed. A patient who is anxious that the ENT department is nervous and frightened after an attempt by a well-meaning amateur is more difficult for the houseman or registrar to deal with and may even need to be given a general anaesthetic for a simple procedure which, if seen untouched on arrival at the department, could well be done without any anaesthesia at all.

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If general practitioners are going to follow this course of action, however, the local hospital must in turn provide a good service to the family doctor. In addition to the routine outpatient clinics a daily treatment clinic should be held by one of the senior house officers so that not only may new cases be seen quickly but the correct daily treatment carried out. So often ENT treatment fails in practice, for example, because of failure to remove debris before antibiotic drops are inserted.

Having been a clinical assistant for over 20 years in a busy department and also having dealt with emergencies in my general practice I have the advantage of seeing both sides of the fence, and my only criticism of fellow practitioners is that they seem reluctant to use the emergency services of the department and are often incorrect in assessing what may be dealt with at home and what should go to hospital. In some areas the facilities provided by the hospital may not be as good as in my own area, and in such cases it is up to the general practitioners to put pressure on the hospital authorities to provide a proper service.

The ears

Earache is perhaps the most painful emergency to which one may be summoned, especially in a small child; most of us are used to the mother telephoning for help, usually in the small hours of the morning, with a screaming child heard clearly in the background. Most of these cases, particularly of sudden onset, are due to middle-ear disease, and a heavy dose of analgesic is the first priority. I have no hesitation in giving an adult dose of Dypiror or paracetamol to a child in such circumstances or in leaving instructions that the dose should be repeated until the pain stops. I have found Auralgan ear drops to be the best pain-relieving drops, and the child should be started on penicillin (double the normal dose for the first 24 hours) given orally as I try to avoid giving injections to children. It may be argued that if adequate analgesia has been achieved by tablets it complicates matters to fill the ear with "treacle." In practice,

10 weeks whatever treatment is used, and permanent paralysis is rare. In its early stages, however, the condition is distressing to the patient, and for this reason I think one must do something positive. My own favourite technique is to prescribe a short, sharp course of steroids starting off with a heavy dose—for example, two 5-mg prednisolone tablets four times daily, reducing over a week to 5 mg twice daily. Referral to hospital for a specialist opinion should follow so that in rare cases of non-recovery the patient feels that the family doctor has done all that he could.

Nose

EPISTAXIS

Epistaxis can be an alarming condition yet in many cases the bleeding can be arrested with simple first-aid measures if timed out properly by the patient. The bleeding area is in most cases from a prominent blood vessel in Little's area, which is at the tip of the nasal septum and can easily be compressed if pressure is exerted by the thumb and forefinger of the right hand applied firmly over the soft tip of the patient's nose. This pressure should be maintained for at least five minutes. Plugging the nose should be avoided as this opens more blood vessels and when the plug is pulled out the bleeding starts again as the dried blood clot is pulled away. If simple first-aid measures do not stop the bleeding then the patient should be dealt with in hospital, especially if the bleeding is arising from further back in the nose.

TRAUMA AND FOREIGN BODIES

Fracture of the nasal bones usually requires reduction in hospital under an anaesthetic within 10 days of the trauma, when the swelling has subsided, but if the doctor is available immediately after the trauma while the nose is still numb a firm push with the thumb on the side of the deformed bone will often result in a satisfying click being heard and felt and no further reduction will be necessary. A case of foreign body inside the nose should also be referred to hospital without interference so that the object may be removed by an experienced operator using the proper equipment and lighting.

Throat and oropharynx
TONSILLITIS

The most common emergency that one meets in general practice is tonsillitis, and in smaller children this may be because of the accompanying high temperature, make the child appear very ill (especially to the relatives) and also often results in infantile convulsions. It is my clinical impression that most cases of infantile convulsions due to hospital for investigation can be sure that an infantile convulsion is due to tonsillitis then I tend to treat the condition at home, but if I am not sure of the diagnosis then it is my general rule to admit all "first time" cases of infantile convulsions to hospital for investigation by paediatricians. Although most cases of tonsillitis respond to oral penicillin, repeated attacks lead to increasing parental anxiety (especially when both parents are out at work) and an increasing number of out-of-hours visits are requested, which are all part of the gentle pressure being exerted for the child's tonsils to be removed. This article is not the place to discuss the pros and cons of tonsillectomy, but these families may often be reassured if left with a starter dose of penicillin to be given at an early stage during an attack. If the general practitioner is clever and plays for time until the child develops his or her own immunity it may be possible to save an unnecessary tonsillectomy.

RESPIRATORY OBSTRUCTION

Perhaps the most dramatic ENT emergency and sometimes one that requires courageous action on the part of the attending doctor is obstruction due to swelling of the tissues of the throat. Doctors who qualified during the preantibiotic era, when diphtheria was common in general practice, had no hesitation in performing a tracheotomy when the signs of laryngeal or pharyngeal obstruction manifested themselves. Most of us who qualified after the war have never had to do an emergency tracheotomy under such circumstances and indeed would be reluctant to perform such a procedure until the patient was almost "in extremis." I have been told that as an emergency first-aid measure a large-bore intravenous needle or chest aspiration needle inserted into the cricothyroid membrane would certainly give a child, and possibly an adult, enough of an airway to at least reach hospital. I have never had to perform such an operation in practice but I do have a large-bore needle in my road accident bag (primarily intended for the relief of a tension pneumothorax). Swelling of the tissues of the throat commonly arise owing to allergic conditions—for example, bee sting, drug reactions—and intravenous chlorpheniramine maleate (Pirnil) may be supplemented by intravenous or intramuscular injections of 100 mg hydrocortisone and also subcutaneous injection of 1 in 1000 adrenaline (up to 0.5 ml as a single dose followed by slow injection at a rate of 0.1 ml per minute). The swelling of the tissues of the throat can also be caused by acute infections, and here is a definite indication for intramuscular injection of antibiotic, penicillin being the first choice.

EPIGLOTTITIS

Epiglottitis that occurs in young children and is sometimes mistaken for croup is a desperate emergency and requires immediate admission to hospital. The epiglottitis swells as a

result of infection due to *Haemophilus influenzae* and this results in laryngeal obstruction, which is also accompanied by laryngeal spasm. The condition is all the more hair-raising for the doctor because the very act of putting a spatula on the tongue can precipitate an acute attack. I have never seen an attack in my general practice but I have been at the hospital receiving end and witnessed more expert colleagues dealing with what is a serious life-threatening condition. The only advice I can give is that one should not forget the possibility of such a diagnosis in any obviously ill and toxic child with symptoms of croup, whose illness started off as a sore throat or upper respiratory infection and developed its present symptoms rather rapidly. One should do no more than a purely visual examination of the back of the throat, and no instruments should be introduced into the mouth. In fact some experts claim even opening the jaws wide can precipitate an attack, so it is probably justified to order the patient to hospital immediately on suspicion alone.

Do what you can but no more

In the final analysis, the successful treatment of ENT emergencies depends on good communication with your local hospital and mutual understanding by the staff of the ENT department and the family doctors of each other's problems, but most important of all I reiterate the advice given in the first part of this article that no doctor should tackle an emergency problem unless he is sure that he is competent to do the job and that he has the right equipment and surroundings to do this properly, otherwise removal to hospital should be the rule rather than the exception so the patient is in the right place at the right time.

I am grateful to Mr Keith Thomas, ENT consultant, Northampton General Hospital, for advice in preparing this article and to Mrs Daphne Brennan, secretary to the department, for secretarial help.

Patient Participation

Aberdare Patients Committee

D J THOMAS

What is a patients committee?

Our patients' committee is an elected body whose sole object is to build up a close relationship between doctor and patient. Medically a close relationship already exists between general practitioners and their patients. Our committee highlights the areas where a closer relationship can exist mainly by means of lectures on primary care and films.

The first committee was set up in 1973 at the request of a general practitioner and patients at the Aberdare Health Centre. It set about making more democratic the relationship between the general practitioners and the patients. The doctors were

Aberdare Health Centre, Mid-Glamorgan
D J THOMAS, chairman

quick to respond and gave the fullest co-operation from the outset. Without that co-operation there cannot be an effective patients committee, for the theme is participation.

Who are the members?

The committee meets once a month. We are 26 members from a patient list of 10 000. In addition there are subcommittees for social activities, lectures, care of the elderly, etc, that meet more often. Committee members are elected at the annual general meeting, which is well advertised in the local press and at the health centre, and an average of 75 people attend. The members of the committee cover a broad spectrum—I am a community health council member, as are two others; there is a person from the old age pensioners group; miners; factory workers; a local editor; teachers; an accountant; county and

local councillors; a nurse; a housewife; and general practitioners. During the past year we have held 11 committee meetings, with an average attendance of 22. All sign an attendance register.

What does the committee do?

We have held 10 public lectures in the past year (over 100 in all on health education, attended by an average of 30 people, some of whom are not patients of the health centre. We have had socials and films and visited hospitals and other Health Service premises. We have entertained 14 doctors and social workers, some from abroad, at meetings. Our last AGM was filmed by the Welsh Arts Council, and a teaching film was made by two patients and a doctor which has been shown in many places. We were also filmed for Grapevine on TV.

We helped to get a psychiatric clinic at the health centre. We run a stroke club, a caring group, a well-woman clinic (committee of three women and a lady GP), and are concerned about cervical screening and screening for the elderly, perinatal mortality, mental health, and the disabled.

We are concerned about the patients who work in collieries and factories and the effect of industrial disease. We make our views known rather forcibly on such matters as ENT and general waiting list delays. We co-operate closely with the community health council and the Age Action Committee and supported a seminar on the problems of the elderly in our community. We work closely with the local housing association, who provide sheltered accommodation and special flats for people who have recovered from mental illness.

Law and the General Practitioner

Committing a patient

S E JOSSE

The rules for committing mentally ill patients to hospital are over 20 years old now and are contained in the Mental Health Act of 1959. Sections 25 to 29 of the Act are particularly important in relation to "admission for treatment" and Section 25 is otherwise known as "admission for observation" and requires medical evidence from two doctors. The period of detention is up to but must not exceed 28 days.

Section 26 is referred to as "admission for treatment" and again requires two doctors independently to provide the medical grounds for admission. The period of detention may be up to one year initially.

In emergency cases one doctor can provide the medical recommendation for admission under Section 29, but the authorised period is reduced to 72 hours from when the patient is admitted.

There are other sections concerned with the compulsory

local councillors; a nurse; a housewife; and general practitioners. During the past year we have held 11 committee meetings, with an average attendance of 22. All sign an attendance register.

What are the benefits of a patients committee?

Members of the committee take the chair at lectures and group meetings and feel that they are helping to promote good health in the community.

The doctor is told about difficulties patients have that only the nurse or receptionist is aware of—such as patients having to wait for a long time to see the doctor; repeat prescriptions of drugs; receptionists taking decisions on matters that are outside their jurisdiction.

The psychological barrier between the doctor and the patient is broken down. The GP must retain his professional status but not allow himself to be above it all. The ideal GP is a friend to the patient.

A more enlightened patient understands the doctor's problems and can be more tolerant, and the GP has a better understanding of the patient's problems and can relate to his patients.

Is a patients committee worth while?

As a member of many volunteer groups in the community, I believe a patient participation committee is the most interesting, instructive, and satisfying of them all. You cannot possibly know what you are missing by not having one. If only all GPs could appreciate the value of a patient participation group in their practices it would go a long way to making for more efficient and satisfying practice—the patient satisfied that he is getting the best service and the GP happy knowing that there is a better understanding between them both.

detention of mentally ill patients, but these are of little or no relevance to the general practitioner.

Criteria for commitment

Certain key criteria must be fulfilled before a patient can be committed: the patient must be suffering from a mental disorder as defined in the Act; the extent of the disorder must warrant detention; the patient does not agree to be admitted to hospital voluntarily; either the patient's own health or safety must be at risk or else other people must require protection from the patient; there must be somebody to make an application for admission; and this application must be supported by either one or two registered medical practitioners.

MENTAL DISORDER

In general terms the Act (Section 4) defines mental disorder as mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind. In the next few subparagraphs of this section, however,

however, the "instant analgesia" provided by drops complements the prolonged analgesia obtained by oral medication, which should err on the side of overdosage rather than underdosage. In most cases of middle-ear infection I prefer to carry on the antibiotic for 10 days instead of five days, which is normal for other upper respiratory tract infections. I certainly continue the antibiotic until there is no increase in temperature, the tympanic membrane appears normal, and any discharge has stopped. Later the child should be followed up to exclude glue ear, which can result in deafness. Some children who are prone to recurrent ear infections may well benefit from prolonged courses of anti-histamine agents when they have a cold or appear to be deaf—for example, Actifed Elkar 5 ml twice daily. In these children adenoids should be excluded as a cause of infection and also the possibility of the ears being infected from recurrent sinus infections.

A perforation may well result from an acute middle-ear infection and this should be observed until it is healed, and if a perforation has not healed in six months the child should be referred for a specialist opinion. In an older child a repair may be considered provided the ear is not chronically discharging, otherwise the graft will break down. The important thing about chronic discharging ears is a correct assessment, and the patient should be referred to a specialist if the discharge does not dry up.

I find that mothers with children who suffer repeated upper respiratory tract infections, particularly earaches, are usually sensible and become expert in forecasting when trouble is liable to erupt, and I have no hesitation in leaving such mothers an emergency starter dose of penicillin which they can make up themselves and give after a telephone consultation with me. I know this is considered lazy doctoring by the purists, but it works, and I have a sinking suspicion that many of my colleagues believe, like me, that prophylactic penicillin and antibiotics protect many ears, save a lot of unnecessary pain, and let us sleep a little longer.

EXTERNAL OTITIS

External otitis can also be an emergency condition, especially when the inflammation results in oedematous swelling which, because of the bony cartilaginous wall of the external canal, results in the epithelium being pushed upwards, narrowing the canal and causing pain for the patient. Secondary infection may give rise to a furuncle and infection can spread back causing perichondritis especially if the furuncle is incised. A swab for bacteriological culture should be taken before treatment starts and in addition to systemic antibiotics local treatment of the painful cause of a furuncle or a grossly narrowed meatus should be started by inserting ichthammol glycerin wick. The ichthammol is bacteriostatic, the glycerin is hygroscopic, and this old-fashioned treatment not only opens the canal but is also very soothing to the patient.

Once the acute painful stage of external otitis has been dealt with it is important to treat the underlying condition. This requires regular daily toilet under direct vision and there may be necessary to refer the patient to an ENT department because it is no use putting in local antibiotic drops if the ear is filled with pus or debris. Prolonged treatment with antibiotic drops may also result in secondary fungal infection, and indeed sometimes patients can be sensitised to the antibiotics in the drops. Proper toilet and keen vigilance are the cornerstones of proper treatment. It is important to assess early on whether the external otitis is due to secondary infection from a middle-ear infection or whether it is associated with a dermatological cause.

Bell's palsy

The most common form of paralysis of the facial nerve is Bell's palsy and fortunately 85% of patients recover within

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