Document Control

Title

Protocol for the Management of Sinusitis in Adults and Children (over the age of 12 years)

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Version	Date Issued	Status	Comment / Changes / Approval
0.1	Apr 2015	Draft	Initial version for consultation
1.0	Apr 2016	Final	Approved by (Clinician) and (Clinical Director) June 2015 and published on BOB
1.1	Sept 2018	Revision	Trust logo changed, antibiotics removed from protocol as per current advice for acute sinusitis. Additional information on diagnostics, tests, referral, red flag criteria inserted. References updated.
2.0	Sept 2018	Final	Reviewed by ED Consultants and approved, ratified by DTC.

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Issue Date	Review Date	Review Cycle
Sept 2018	Aug 2021	Three years

Consulted with the following stakeholders: • ED Consultant • MIU Leads	**Contact responsible for implementation and monitoring compliance:** Professional lead, MIU **Education/ training will be provided by:** Professional lead, MIU
Approval and Review Process • DTC	

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CONTENTS

1. Purpose

- This protocol is for the use by staff employed by NDHT who have achieved the agreed clinical competencies to work under this protocol

2. Presenting Symptoms

Nasal congestion or discharge (posterior or anterior nasal drip)

With any or all of the following:

- Reduced smell (hyposmia)
- Facial pain / pressure / tenderness predominantly on one side
- Adults: Headache – worse on leaning forwards
- Children: Cough (daytime and night-time)

Other features which may suggest sinusitis (but are not by themselves diagnostic) in adults:

- Altered speech indicating nasal obstruction.
- Tenderness, swelling, or redness over the cheekbone or periorbital areas.
- Cough.
- Pain on mastication
- Toothache (maxillary)
- Purulent nasal discharge (Rhinorrhea)

3. History

3.1. Refer to Standard Operating Procedure for History Taking and Clinical Documentation.

3.2. Ask about and document all findings fully – positive and negative in case of future litigation:

- Take an allergy history
- Previous medical history:
  - Ask about recent viral illness – acute sinusitis usually follows a common cold
  - Allergic rhinitis
  - Asthma
  - Immunosuppression
  - Previous episodes of sinusitis, and how these were managed
  - Previous episodes of tonsillitis / adenoiditis
  - ENT/maxillofacial surgery or history of injury or trauma to nose/forehead/face
  - Known or suspected ENT tumour (sinonasal tumour)
  - Current radiotherapy in head/neck
  - History of neuropathic or atypical facial pain, or trigeminal neuralgia
  - History of migraine
  - History of giant cell arteritis
  - Dental problems, or recent dental work
  - Temporomandibular joint dysfunction

- History of, or current nasal polyps

- Take a medications history, particularly ask about the following:
  - Nasal decongestant sprays
  - NSAIDs
  - Beta blockers
  - ACE Inhibitors
  - HRT or contraceptive pill
  - Thyroid medication
- Onset of symptoms – acute sinusitis is defined as an increase in symptoms after 5 days of having a cold, or persistence beyond 10 days, but less than 12 weeks; chronic sinusitis is persistence of symptoms beyond 12 weeks without complete resolution.
- Ask about the following:
  - Smoking history
  - Occupation (e.g. cleaner, builder, carpenter and risk of exposure to fumes)
  - Alcohol history
  - Diet – spicy food
  - Stress – lifestyle, work
  - Piercings, prosthetic material in affected area(s) and when these were inserted
  - For children and adults with cognitive impairment: ask about history of fiddling with small objects which could be inserted up the nose
- Self-care measures tried at home
- Any current treatment for the episode of sinusitis

4. Clinical Examination

4.1. Examine the patient and document fully the following information, positive and negative findings in case of future litigation:

- Observe for systemic symptoms
- Pallor
- Flushed
- Lethargy
- Malaise
- Pain
- Pyrexia
- Dehydration
- Acute onset of confusion
- Record vital signs and EWS, include temperature
- Record colour, site and consistency of any crusting or discharge
- Look for rashes, and record location and appearance
- Look at surgical or piercing sites for inflammation/infection
- Inspect and palpate the maxillofacial area to elicit swelling and tenderness.

- Perform anterior rhinoscopy (using the largest speculum of an otoscope, or a head light and nasal speculum) to identify:
- Signs which support a diagnosis of acute sinusitis such as nasal inflammation, mucosal oedema, and purulent nasal discharge.
- Associated pathology such as nasal polyps, or anatomical abnormalities such as septal deviation.
- Record pulse rate, blood pressure, and temperature if the person is systemically unwell.

- Suspect acute bacterial sinusitis when several of the following features are present:
  - Symptoms for more than 10 days
  - Discoloured or purulent nasal discharge (with unilateral predominance).
  - Severe local pain (with unilateral predominance).
  - A fever greater than 38°C.
  - A marked deterioration after an initial milder form of the illness (so-called 'double-sickening').
  - If blood testing facilities are available, elevated ESR/CRP (although the practicality of this criterion is limited).
- Suspect chronic rhinosinusitis if presenting symptoms in addition to objective evidence of sinonasal inflammation on examination
  - Signs which support a diagnosis of chronic sinusitis such as nasal inflammation, mucosal oedema, and mucopurulent nasal discharge.
  - Associated pathology such as nasal polyps, or anatomical abnormalities such as septal deviation
- **Do not routinely request laboratory investigations or radiographic imaging** for people who meet diagnostic criteria for acute uncomplicated sinusitis.

4.2. Investigations

- Patients scoring for sepsis criteria: take FBC, blood cultures x2 sets, U+Es
- **Do not send microbiological samples of nasal discharge**, this is unlikely to be useful in the MIU setting.

5. Exclusions and Referral

5.1. Exclusions (refer to medical practitioner on a non-urgent basis):

- Children under 12 years of age
- Pregnant women
- Immunocompromised patients, and those on immune suppressing medications
- Patients with allergy to tetracyclines
- Patients with liver impairment
- Patients with symptoms for less than 10 days who are otherwise systemically well
- Non-infectious or chronic sinusitis
- Patients who have already been prescribed tetracycline antibiotics for sinusitis

- Patients with nasal polyps, or history of ENT surgical procedure(s)
- Recurrent acute sinusitis (more than 3 episodes requiring antibiotics in a year)
- Treatment failure after extended courses of antibiotics

5.2. Refer on an urgent basis:

- Foreign body requiring imaging, or practitioner unable to remove safely in MIU setting
- Urgently refer patients to hospital who are too systemically unwell to be safely discharged home, or who show signs of sepsis on examination
- Urgently refer patients to hospital who present with:
  - Intraorbital or periorbital complications, including periorbital oedema or cellulitis, a displaced eyeball, double vision, ophthalmoplegia, or newly reduced visual acuity.
  - Intracranial complications, including swelling over the frontal bone, symptoms or signs of meningitis, severe frontal headache, or focal neurological signs – consider transfer straight to RD&E under ENT via blue light ambulance if severe and patient has presented to MIU outside of NDDH
  - Epistaxis which is unresolving and/or airway compromise – consider arranging transfer straight to RD&E under ENT via blue light ambulance if severe and patient has presented to MIU outside of NDDH
- Urgent referral via GP for further investigations under 2 week wait rule for any patients who present with unilateral symptoms, small volume epistaxis which safely resolves in MIU, blood-stained nasal discharge without signs of infection, any polyp/tumour/lesion identified during clinical examination
- Urgently refer all children to hospital who are identified as intermediate or high risk using the Traffic Light System in the Feverish Illness in Children Guideline (NICE May 2013).
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6. Treatment

6.1. Patients who are not systemically unwell but in whom symptoms are suggestive of bacterial infection **and** which have persisted or worsened over a week: Refer to their own GP (or Devon Doctors service if over a long bank holiday weekend), with safety-netting advice about red-flag symptoms.

7. Self-Care Advice

7.1. Reassure patients who do not need antibiotics that sinusitis is usually uncomplicated and will improve without antibiotic treatment within 3 weeks. Provide information about red flag signs which should prompt them to present again for help.

7.2. Paracetamol and/or ibuprofen may be used as an antipyretic and/or analgesic for fever and pain. NSAIDs are less preferred if no antibiotic is being given (some evidence that these can worsen recovery)

- Patients should be encouraged to purchase these items OTC in line with new NHS recommendations. If out of hours, or significant difficulty obtaining a supply due to social circumstances, consider using PGD to supply.

7.3. Nasal saline douches, steam inhalation or simple (non-medicated) nasal decongestants may be of benefit for symptom relief. If these measures are insufficient, recommend seeking an appointment with GP for consideration of medicated steroid nasal spray.

8. Discharge Pathway

8.1. Assess and document pain score prior to discharge

Ensure patient is issued with appropriate advice sheet (if available) and that patient understands the need to return if symptoms change or worsen. Advise patients to see their GP if no better in a 10-14 days, or sooner if their symptoms worsen and include red flag signs

Discuss home analgesia with patient, parent or carer and advise OTC medication or supply TTO medication as per PGD.

8.2. Documentation To Be Completed

- Clinical treatment record as per Documentation & record keeping policies. Copy of clinical treatment record to General Practitioner; to be sent to surgery as per Record keeping policy.
- For patients being transferred to secondary care, ensure a copy of the clinical treatment record is sent with patient. A copy will also be sent to surgery in normal manner.
- **For patients seeing their General Practitioner in next 24 hours ensure patient is given a copy of the clinical treatment record to take with them. A copy will also be sent to surgery in the normal manner.**

8.3. Before Discharge Ensure

- Those patients who have been referred for further acute intervention has appropriate transport to meet their needs, all relevant treatment has been prescribed and administered and correct information and documentation is given to the patient.
- The patient understands that if condition deteriorates or they have further concerns they should seek further advice.
- The patient demonstrates understanding of advice given during consultation.
- The patient has been provided with written advice leaflet to re-enforce advice given during consultation.
- The patient demonstrates an understanding of how to manage subsequent problems.

9. References

- PHE. 2017. Management and Treatment of Common Infections. Antibiotic guidance for primary care: For consultation and local adaptation. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664740/Managing_common_infections_guidance_for_consultation_and_adaptation.pdf
- NICE. 2018. Clinical Knowledge Summaries: Sinusitis. https://cks.nice.org.uk/sinusitis
- Feverish Illness in Children CG160 https://www.nice.org.uk/guidance/cg160/resources/support-for-education-and-learning-educational-resource-traffic-light-table-189985789
- BNF and BNFC https://www.new.medicinescomplete.com/mc/
- NEW Devon CCG. 2017. https://northeast.devonformularyguidance.nhs.uk/formulary/chapters/5.-infections/

10. APPENDIX A – Essential Documentation for All Patients Attending Unit or Centre

Adults Consent
Gain consent to be seen by a nurse practitioner
Gain consent for treatment and sharing information and document.

Clinical Presentation
If unwell assess for:

- Airway
- Breathing
- Circulation
- Disability
- Exposure

Document a full set of observations including neurological observations including Glasgow coma score if applicable.

Record EWS: if 7 or above arrange immediate transfer to secondary care.

Document pain score using numeric rating scale. For cognitively impaired patients document any signs of pain (e.g. grimaces or distress).

Safeguarding

- Assess for mental capacity and if person is a vulnerable adult.
- Assess for learning disability and whether patient has a hospital passport in place.
- Assess for risk of domestic abuse.
- Assess falls risk. Complete falls referral if applicable.
- Document names of persons accompanying patient.

11. APPENDIX B – Essential Documentation for All Patients Attending Unit or Centre

Child and Young Persons under 18 Years Old Consent
Gain consent to be seen by a nurse practitioner
Gain consent for treatment and sharing information
Assess and document Gillick competency according to Fraser guideline if applicable.
Document name of person's accompanying patient

Clinical Presentation

If unwell assess for:

- Airway
- Breathing
- Circulation
- Disability
- Exposure

Record PEWS: if any one parameter is triggered transfer to secondary care or seek advice from medical practitioner.

Use guideline Traffic Light System (NICE) 2013 if applicable.
Use guideline Feverish Illness (NICE) 2013 if applicable.
Document pain score using FLACC, Wong Baker Faces or numeric rating scale.

Safeguarding

- Assess safeguarding
- Assess for domestic abuse in the home
- Assess for learning disability

DOCUMENT ALL FINDINGS IN THE CLINICAL TREATMENT RECORD AND ACT ON THEM FOLLOWING NDHCT GUIDELINES.

12. APPENDIX C – Training Competency Form

Protocol for the Management of Sinusitis in Adults and Children (12 years and over)

Protocol operational from December 2018 and expires end of November 2020

The registered health professional named below, being employees of Northern Devon Healthcare Trust based at ……. have received training and are competent to operate under this protocol

NAME *(please print)*	PROFESSIONAL TITLE	SIGNATURE	AUTHORISING MANAGER *(please print)*	MANAGER'S SIGNATURE	DATE

Keep original with the authorising manager and send a copy to: Karen Watts, Emergency Department, Northern Devon Healthcare Trust NHS, Raleigh Park, Barnstaple, Devon, EX31 4JB