ENT Referral Guide

Austin Health Ear Nose Throat (ENT) Unit holds fortnightly multidisciplinary meetings with Plastics, Oncology, Maxillofacial units to discuss and plan the treatment of patients with Head and Neck conditions.

Department of Health clinical urgency categories for specialist clinics					
For emergency cases please send the patient to the Emergency department.					
Urgent: Referrals should be categorised as urgent if the patient has a condition that has the potential to deteriorate quickly, with significant consequences for health and quality of life, if not managed promptly. These patients should be seen **within 30 days** of referral receipt.					
Routine: Referrals should be categorised as routine if the patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if specialist assessment is delayed beyond one month.					
Exclusions: **see guidelines under Condition /Symptom and refer to website- www.health.vic.gov.au/surgery>**					
Condition / Symptom	**GP Management**	**Investigations Required Prior to Referral**	**Expected Triage Outcome**	**Expected Specialist Intervention Outcome**	**Expected number of Specialist Appointments**
NECK MASS					
Neck Mass/Lump **Direct to an appropriate emergency department for an ENT assessment:** • Sudden or new mass or lump associated with difficulty in breathing or swallowing • Sialadenitis with difficulty in breathing • Ludwig's angina.	**When to Refer:** • Confirmed head and neck malignancy • New suspicious solid mass, or cystic neck lumps, present for more than four weeks • New suspicious solid mass, or cystic neck lumps, in patents with a previous head / neck malignancy	**Clinical history and examination:** Document detail history of mass History of smoking, excessive alcohol intake Provide if available: Any of the following: 1. History of smoking 2. Excessive alcohol intake 3. Full blood count 4. Fine needle aspiration biopsy **Imaging:** CT scan of neck, with contrast where appropriate (preferred) or ultrasound	**Urgent:** **Immediately contact the ENT registrar to arrange an urgent ENT assessment for:** Acute inflammatory neck mass with redness, pain or increased swelling.		

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Department of Health clinical urgency categories for specialist clinics					
Immediately contact the ENT registrar to arrange an urgent ENT assessment for: Acute inflammatory neck mass with redness, pain or increased swelling.	• Sialadenitis.				

Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
Thyroid Mass **Direct to an appropriate emergency department for:** Thyroid mass with difficulty in breathing or with bleeding from the nodule.	Completion of head and neck examination Check generalised or localised thyroid enlargement **When to Refer:** Suspected or confirmed malignancy Compressive symptoms: changing voice difficulty in breathing dysphagia suspicious dominant nodules or compressive neck nodes.	**Clinical history and examination:** Document any signs of dysphagia, dyspnoea or hoarseness **Imaging:** Thyroid US with or without FNA **Diagnostics:** TFTs **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent** Referrals for patients with hyperthyroidism should be directed to the endocrinology service.		As required

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Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
	Generalised thyroid enlargement without compressive symptoms Recurrent thyroid cysts An increase in the size of previously identified benign thyroid lumps > 1cm in diameter. **Referral to a public hospital is not appropriate for:** Non-bacterial thyroiditis Uniform, enlarged gland suggestive of thyroiditis without other symptoms.				
Salivary Gland Mass **Direct to an appropriate emergency department for:** • Salivary abscess associated with: • swelling in the neck • difficulty in breathing. **Immediately contact the ENT registrar to arrange an urgent ENT assessment for:** • Acute salivary gland inflammation unresponsive to treatment • Sialadenitis in immunocompromised patients, or facial nerve palsy	Evaluation of facial nerve function with parotid lesions Consider FNA **When to refer:** Confirmed or suspected tumour or solid mass in the salivary gland Symptomatic salivary stones with recurrent symptoms unresponsive to treatment.	**Clinical history and examination:** History of symptoms Location of site(s) of mass History of skin cancers removed History of smoking. **Provide if available:** Ultrasound results CT scan results. FNA results **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent:** Confirmed or suspected Tumour **Additional Comments:** Referrals for patients with mumps or patients with HIV with bilateral symptoms should be directed to an infectious disease service. Referrals for patients with Sjogren's syndrome should be directed to a rheumatology service.		As required

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Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
Paediatric Neck Mass		**Clinical history & examination:** Detailed history of mass Imaging: US +/- FNA, MCS, AFB, no CT neck **Diagnostics:** FBE, CRP, EBV, CMV serology Consider Bartonella serology, Toxoplasmosis, HIV titre if indicated	**Urgent** Increasing size - Not responding to antibiotics Persisting > 6 weeks **Semi-urgent** Suspected thyroid mass All other neck masses		
NASAL AND SINUS					
Rhinosinusitis **Direct to an appropriate emergency department for:** Complicated sinus disease with: • orbital and / or neurological signs • severe systemic symptoms • periorbital oedema or erythema • altered visual acuity, diplopia, or reduced eye movement.	**When to refer:** New and persistent unilateral nasal obstruction present for more than four weeks Rhinosinusitis that **has not** responded to three months of intranasal steroid and nasal lavage treatment. **Referral to a public hospital is <u>not</u> appropriate for:**	**Clinical history and examination:** Presence of epistaxis Details of previous medical management including the course of treatment (e.g. intranasal steroid, nasal lavage or antibiotics) and outcome of treatment. Consider skin prick/RAST/IgE CT sinuses (non- contrast)			

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	• Patients with headaches who have a normal CT scan which has been performed when the patient has symptoms • Patients who have not had three months of intranasal steroid and nasal lavage treatment.	**Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**			
Nasal Obstruction/Congestion	• Manage co-existing allergies /asthma • Antihistamine for allergic rhinitis • Saline rinse/irrigation • Intranasal steroid sprays (e.g. mometasone) Assess symptoms unilateral/bilateral, altering postnasal discharge, recurrent sinusitis Intranasal examination after decongestion- polyps, deviated septum, enlarged turbinates Consider referrals to allergy specialist	**Clinical history and examination:** Document symptoms, duration & treatments trialled **Diagnostics:** Consider skin prick/RAST/IgE CT sinuses (non- contrast) **Instruct patient to bring films (CT) & diagnostic results to the Specialist Clinic appointment**	**Urgent** Unilateral polyps Bloody discharge **Routine** Bilateral polyps Allergic rhinitis not responding to maximal medical management		As required

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Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
	When to refer: Nasal obstruction that **has not** responded to three months of intranasal steroid and nasal lavage treatment. Please arrange CT sinuses (non- contrast) and include report with referral.				
Epistaxis- persistent or recurrent **Refer to ED if** · Large volume epistaxis · Hemodynamically unstable	Educate patient on applying pressure on nostrils Consider cautery with silver nitrate Intranasal pack Assess whether bleeding in unilateral or bilateral Determine whether bleeding in anterior or posterior Determine if coagulopathy/platelets disorder or if Hypertension present	**Clinical history and examination:** Examination findings Document medications- NSAIDS, aspirin, warfarin etc. Provide if known: History of bleeding disorder **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent:** Suspicion of tumour **Semi-urgent:** Unilateral epistaxis in adolescent male/suspicion of juvenile nasopharyngeal angiofibroma (JNA) **Routine:** Not responding to maximal medical treatment (topical cream, cautery)		As required
Chronic Sinusitis/Polyposis	Trial antihistamines, antibiotics intranasal sprays Intranasal examination after decongestion	**Clinical history and examination:** Document symptoms, duration and treatments tried	**Routine:** Chronic & recurrent not responding to maximal medical management		As required

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Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
	When to refer: If abnormal symptoms persist and/or abnormal findings	**Imaging:** CT scan (non contrast) **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**			
Acute Sinusitis **Refer to ED if any Complications:** · Periorbital cellulitis · Orbital abscess · Rapidly evolving symptomatology in immunosuppressed patient	Trial Antihistamines, Intranasal steroids and/or antibiotics Consider oral steroids Assess signs of Unilateral or bilateral nasal congestion including: • Purulent discharge • Dental pain • Facial, forehead o periorbital • Persisting URTI >7 days **When to refer:** If not responding to medical management. **Referral not appropriate for:** If treatment relieving symptoms	**Clinical history and examination:** Document symptoms, duration and treatments tried **Diagnostics:** CT sinuses (non- contrast) **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent:** If treatment not successful **Referral not appropriate for:** If treatment relieving symptoms		As required
Acute Nasal Fracture:	**Referral not appropriate for:** The nose is not bent, or there is no new deformity, or there is no obstruction		As patients with an acute nasal fracture should be referred to an appropriate emergency department for ENT assessment, public hospital specialist clinics should not receive any		

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Direct to an appropriate emergency department for an ENT assessment: • Acute nasal fracture with septal haematoma. • A new injury where the nose is bent, there is a compound fracture or epistaxis that fails to settle. • Please refer within a week of the injury and indicate the date and mechanism of the injury.			referrals for this presenting Problem. Except to arrange GAMP within 1 week following ENT assessment.		
Facial Pain	Assess whether associated with significant: • Nasal congestion or discharge • TMJ dysfunction • Dental pathology, sinus, pathology • Intranasal deformity. If evidence of acute sinusitis- commence treatment	**Clinical history and examination:** Document symptoms, duration and treatments tried **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Routine** **Additional notes:** Consider referral to neurology +/- dentist in the absence of nasal symptomatology or normal CT sinus		As required
PHARYNGEAL, TONSILITIS & ADENOID					
Obstructive sleep apnoea	**When to refer:**	**Clinical history and examination:**			

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Immediately contact the ENT registrar to arrange an urgent ENT assessment for: Rapid progression of obstructive sleep apnoea.	Obstructive sleep apnoea with: Nasal obstruction Macroglossia. **Additional Comments:** Referrals for other forms of obstructive sleep apnoea should be directed to a multidisciplinary sleep clinic or respiratory service.	History of symptoms over time and burden of symptoms, sleep quality (especially the story from partner), waking during the night and level of tiredness (including Epworth Sleepiness Scale) Patient's weight If the patient is taking an antidepressant medicine. **Provide if available:** Recent polysomnography results. **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Semi Urgent** **Note – Referral may be declined or redirected if more appropriate for respiratory or sleep service.**		
Acute tonsillitis **Emergency Department for:** • Not tolerating oral intake • Airway issues • Evidence of quinsy	Treat with antibiotics (as per Antibiotic Therapeutic Guidelines) Document frequency of attacks	**Clinical history and examination:** Frequency of attacks, previous peritonsillar abscess/quinsy, any bleeding history	**Urgent:** Between 7-10 days **Semi Urgent:** Post 10days **Routine:**		As required

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Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
	Document tonsillar exudate **When to refer:** **Consider this**	**Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**			
Recurrent tonsillitis **Direct to an appropriate emergency department for:** Abscess or haematoma (e.g. peritonsillar abscess or quinsy) Acute tonsillitis with: difficulty in breathing unable to tolerate oral intake uncontrolled fever. Post-operative tonsillar haemorrhage.	Treat with antibiotics Document frequency of attacks Document tonsillar exudate **When to refer:** Chronic or recurrent infection with fever or malaise and decreased oral intake and any of the following: • four or more episodes in the last 12 months • six or more episodes in the last 24 months • tonsillar concretions with halitosis • absent from work or studies for four or more weeks in a year. Suspicious unilateral tonsillar solid mass with or without ear pain.	**Clinical history and examination:** History of tonsillitis episodes and response to treatment If the patient is taking anticoagulant, or any other medicine that may reduce coagulation, or if there is a family history of coagulation disorder. **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent:** More than 6 episodes in 1 year or 4 per year over 2 years. **Referral to a public hospital is not appropriate for:** • If the patient is not willing to have surgical treatment • Halitosis without other symptoms.		As required

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Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
Peritonsillar cellulitis/Abscess **Quinsy** **Emergency Department for:** • Not tolerating oral intake • Airway issues • Evidence of quinsy	Treat with antibiotics (as per Antibiotic Therapeutic Guidelines) **When to refer:** Always	**Clinical history and examination:** Stridor, voice change, trismus, airway concerns **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent:**		As required
Infectious Mononucleosis **Viral Pharyngitis** **Emergency Department for:** • Not tolerating oral intake • Airway issues • Evidence of quinsy	Monospot / EBV serology if suspect EBV tonsillitis **When to refer:** If not responding to treatment	**Clinical history and examination:** **Diagnostics:** Monospot test / EBV serology FBE, UE, CRP **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent:**		
Adenoiditis hypertrophy **+ Upper airway obstruction**	Treat with antibiotics (as per Antibiotic Therapeutic Guidelines) Document all symptoms **When to refer:** If not responding to treatment	**Clinical history and examination:** Document all symptoms inc: Nasal obstruction, nasal discharge, systemic features **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent:** Severe symptoms present directly to ED.		

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Neoplasm **Please call ENT Registrar via Austin Switchboard to discuss**	Treat with antibiotics (as per Antibiotic Therapeutic Guidelines)	**Clinical history and examination:** Document all symptoms Risk factors: smoking, alcohol intake, airway issues, previous malignancy **Diagnostics:** CT neck (with contrast), US neck + FNA **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent:**		
HOARSENESS					
Hoarse voice (dysphonia) **Direct to an appropriate emergency department for:** Hoarse voice associated with difficulty in breathing or stridor Hoarse voice associated with acute neck or laryngeal trauma.	Commence where indicated: • Rest voice • Antibiotics • Inhalant steroid sprays • Humidification • Smoking cessation • Reduce caffeine intake **When to refer:** • Persistent hoarseness, or change in voice quality, which fails	**Clinical history and examination:** Document all symptoms If patient is a professional voice user Any of the following: • History of smoking • Excessive alcohol intake • Recent intubation • Recent cardiac or thyroid surgery. • Recent neck trauma **Instruct patient to bring films & diagnostic results**	**Urgent:** If symptoms persisting over 4wks & any of following: • History of smoking • Excessive alcohol • Recent intubation/previous tracheostomy • Recent cardiac or neck surgery **Semi-Urgent** Recurrent symptoms in patients with no risk factors		

Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
	to resolve in four weeks • Recurrent episodes of hoarseness, or altered voice, in patients with no other risk factors for malignancy.	**to the Specialist Clinic appointment**			
EARS					
Discharging ear **Immediately contact the ENT registrar to arrange an urgent ENT assessment for:** • Ear discharge with moderate to severe persistent ear pain, persistent headache, cranial nerve neuropathy or facial palsy • Malignant otitis externa • Suspected skull base osteomyelitis • Cellulitis of the pinna • Suspected mastoiditis • Osteitis ear.	**When to refer:** • Non-painful discharging ear for longer than two weeks that fails to settle with treatment. • Otorrhea clear discharge • Cholesteatoma.	**Clinical history and examination:** Document all symptoms Provide if available • History of smoking • Excessive alcohol intake. **Diagnostics:** Microscopy, culture and sensitivity (MCS) ear swab. **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**			

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Acute Otitis Media (AOM) **Direct to an appropriate emergency department for an ENT assessment:** • Facial Nerve Palsy • Acute Mastoiditis • Subperiosteal abscess (pinna protrusion) • Meningitis/encephalitis	Start broad spectrum antibiotics Start Analgesia Children: start topical decongestants Adult: start systemic decongestants **When to refer:** • Cholesteatoma • Syndromic, craniofacial abnormalities, cleft palate • Recurrent AOM • AOM with TM perforation with persisting concerns >6weeks	**Clinical history and examination:** Document all symptoms including: Otalgia Fever Otorrhea **Diagnostics:** Microscopy, culture and sensitivity (MCS) ear swab. **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Semi Urgent:** Cholesteatoma Syndromic, craniofacial abnormalities, cleft palate **Routine:** AOM with TM perforation with persisting concerns >6weeks Recurrent AOM (>3 episodes in 6 months or > 4 episodes in 12 month)		
Otitis Media with Effusion' Glue Ear"	Start systemic antibiotics and at least one course B-Lactamase resistant antibiotic **When to refer:** Ongoing symptoms	**Clinical history and examination:** Document all symptoms URTI, hearing loss, speech/developmental delay, indigenous background **Diagnostics:** Microscopy, culture and sensitivity (MCS) ear swab.	**Semi-urgent** TM abnormalities (cholesteatoma, TM retraction) Speech / developmental delay Severe hearing loss **Routine** Mild hearing loss		

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Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
Acute Otitis Externa	Apply topical antifungal or antibiotic therapy as indicated Start systemic antibiotics if cellulitis around canal. Insert ear wick if canal oedematous Avoid syringing Avoid using hearing aids **When to refer:** If not responding to medical management.	**Clinical history and examination:** Document all symptoms Otalgia Otorrhea **Diagnostics:** Ear swab MCS, including fungus **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent** Confirmed otitis externa & persistent sx & pain Hearing loss despite maximal medical management **Semi-urgent** Confirmed otitis externa without pain		
Foreign Bodies **Refer to ED if** · Suspicion of button battery · ingestion/inhalation	Remove if only technically able, stop immediately if any bleeding	**Clinical history and examination:** Document all symptoms Type of foreign body, duration **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent**		
HEARING LOSS					
Bilateral or asymmetrical hearing loss	Cerumen dissolving ear drops **When to refer:**	**Clinical history and examination:** Document all symptoms	**Urgent:** • rapid progressive severe unilateral or bilateral SNH		

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Direct to an appropriate emergency department for an ENT assessment and commencement of treatment: • Sudden onset hearing loss in the absence of clear aetiology • Sudden hearing loss due to trauma or vascular event • Sudden, profound hearing loss.	• Asymmetrical hearing loss with significant impact on the patient • Sensorineural hearing loss confirmed by diagnostic audiology assessment • Symmetrical hearing loss caused by ototoxic medicine(s). **Referral to a public hospital is not appropriate for:** • Symmetrical gradual onset hearing loss • Symmetrical age-related hearing loss • Patients with a normal audiogram.	Description of hearing loss or change in hearing **Diagnostics:** Results of diagnostic audiology assessment. **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	• unilateral vertigo/tinnitus **Routine:** Other eligible referrals		
TINNITUS					
Tinnitus	**If non-pulsatile GP Management:** Clear cerumen	**Clinical history and examination:** Document all symptoms	**Urgent:** Pulsatile - to rule out tumour Vertigo Hearing loss Otalgia		

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Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
	Check TM-if clear no treatment **When to refer:** • Recent onset of unilateral tinnitus • Pulsatile tinnitus present for more than six months.	Results of diagnostic audiology assessment. **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	Otorrhea **Non Urgent:** Recent onset unilateral		
DIZZINESS					
Vertigo (ENT): **Direct to an emergency department for:** Sudden onset debilitating vertigo where the patient is unsteady on their feet or unable to walk without assistance Barotrauma with sudden onset vertigo, or symptoms suggestive of stroke or transient ischaemic attacks.	Important to rule out central causes · • Consider possible causes (migraine, medications, orthostatic or cardiac) • If Dix Hallpike Test positive, perform repositioning manoeuvre (Epleys, log roll) • Consider referring for vestibular physiotherapy • Consider safety, falls prevention **When to refer:**	**Clinical history and examination:** Results of diagnostic vestibular physiotherapy assessment or Epley manoeuvre Results of diagnostic audiology assessment Onset, duration, nature and frequency of vertigo. **Provide if available:** Description of any of the following:	**Urgent:** Sudden onset associated with barotrauma **Routine** BPPV refractory to repeated repositioning manoeuvre or after seeing vestibular physiotherapist **Additional Comments:** Chronic or episodic vertigo and vertigo with other neurological symptoms		

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	Vertigo that has not responded to vestibular physiotherapy treatment.	• Functional impact of vertigo • Any associated otological or neurological symptoms • Any previous diagnosis of vertigo (attach correspondence) • Any treatments (medication or other) previously tried, duration of trial and effect • Any previous investigations or imaging results • Hearing or balance symptoms • Past history of middle ear disease or surgery. History of any of the following: • Cardiovascular problems • Neck problems • Neurological • Auto immune conditions • Eye problems • Previous head injury	should be directed to a neurology service.		

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FACIAL PARALYSIS					
Facial Paralysis	Eye protection if incomplete closure - Lacrilube & tape eye shut nocte If suspicious of Bell's palsy or Ramsay Hunt Syndrome: • Consider steroid treatment if indicated • Anti-viral treatment if associated with vesicles **When to refer:** Acute facial paralysis.	**Clinical history and examination:** Immediate vs delayed, complete vs incomplete, trauma, surgery, otological sx, hx of skin or head/neck malignancy **Diagnostics:** If relevant, CT temporal bone/neck, Audiogram **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Urgent:** Lower motor neuron + hearing loss/otalgia/otorrhea/other cranial nerve palsy Vesicles in ear or oral cavity Perineural spread from cutaneous SCC - No improvement or worsening palsy despite treatment		
DYSPHAGIA					
Dysphagia **Direct to an emergency department for:** Sudden onset of inability to swallow Inability to swallow Swallowing problems accompanied by difficulty in breathing or stridor Difficulty in swallowing caused by a foreign body or solid food.	Consider referring to Speech Pathologist +/- Neurology **When to refer:** Oropharyngeal or throat dysphagia with either: • hoarseness • progressive weight loss • history of smoking	**Clinical history and examination:** History of symptoms over time History of smoking History of excessive alcohol intake. **Imaging:** Chest x-ray Barium swallow Soft tissue studies of neck	**Urgent:** Suspicion of oropharyngeal lesion Hoarseness Unilateral otalgia Progressive weight loss Significant dysphagia + - Gagging/choking/coughing on swallowing Food or liquid regurgitation Recurrent chest infection		

Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
	• excessive alcohol intake. Progressively worsening oropharyngeal or throat dysphagia Inability to swallow with drooling or pooling of saliva.	Thyroid studies **Instruct patient to bring films & diagnostic results to the Specialist Clinic appointment**	**Additional Comments:** Referrals for oesophageal dysphagia should be directed to a gastroenterology service		