Ear, Nose and Throat Examination

14.12.1956.

No. 4.

N. Johnston

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E. N. T.

1. The symptoms caused by an excess of wax in the ears would be deafness and a feeling of "stuffiness" in the head. The patient will most likely have gone suddenly deaf after washing his face and neck and allowed some water to enter his ears; this makes the wax swell and cover the tympanic membrane.

It may also cause irritation, slight pain, and giddiness. Occasionally it may also cause tinnitus.

It would be treated by first examining the ear with an auriscope to determine the nature of the blockage. When this has been ascertained it is wax, an ear syringing tray is set up. The ear is pulled back and the nozzle of the syringe is pointed slightly upwards and backwards into the meatus, and gently syringed. If the cerumen does not dislodge after two or 3 tries softening drops, such as hydrogen pyroxide or glycerine, are instilled and the patient should return later to have the wax removed.

After syringing the ear should be again examined with an auriscope and gently dried with cotton wood on wire wool carriers. The ears after syringing should always be examined by the Doctor to see that there is no damage to the ear drum or any bleeding.

auroscope

An ear syringing tray should contain:

2 kidney dishes
jug of lotion - warm sodium bicarbonate or saline.
aural syringe and 3 specula.
1 bowl of swabs
2 wire wool carriers.

Also angular aural forceps.

At hand should be

an Auriscope
Mackintosh cape + towel for patient
Glycerine or Hydrogen Peroxide drops
Mackintosh cape for the nurse.

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2. Tracheotomy: is the term used to describe an opening into the trachea. It is usually performed to insert a tracheotomy tube to maintain a permanent or temporary artificial airway in cases of laryngeal ~~or pharyngeal disease~~.

It may be done as an emergency measure to enable the patient to breathe while other conditions are being treated. Obstructions may be caused by membranes blocking the throat in Diphtheria, sometimes when foreign bodies are firmly lodged between the oro-pharynx and larynx, when corrosive or irritant mixtures have been swallowed and in cases of severe laryngeal spasms.

It is sometimes ~~done~~ planned, as when ~~they~~ the patient has an irrepairable injury to the throat or cancer of the vocal cords or larynx. — in other words as a preliminary to a major operation on the Larynt.

After the patient has had a tracheotomy he should never be left, as he cannot call out for any needs. A tray should be kept near the bed containing sterile tracheal dilators and a tracheotomy tube in case the tube already in position comes out.

The inner tube should be cleaned frequently with swab sticks and sterile swabs ~~(to clean the inner tube)~~ moistened in sodium bicarbonate solution. It should be taken out and thoroughly cleaned every two hours. The gauze covering the tube should be changed immediately it is soiled. The patient may like his mouth moistened after being given mouth toilet. These should be done at least four hourly.

The patient is placed in semi-Fowler's position and kept as comfortable as possible. If there is still some obstruction a steam kettle and tent may be necessary. Fluids may be given orally once the patient is well enough otherwise they are given intravenously or rectally. Oxygen should be at hand.

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3. An antrum washout is performed to diagnose and/or treat chronic maxillary sinusitis or to remove any collection of fluid in the antrum. Also in acute sinusitis.

The instruments required are - Thudicum's speculae.
Trocar and cannula.
Higginson's syringe
Nasal angle forceps.
Jug of tepid normal saline.

There should also be a good light and head-mirror or head lamps for the surgeon.

Decongestant drops may be necessary if the patient has rhinitis

A local anaesthetic is used - this is usually Xylocaine 2% and may be injected locally, but is more often applied with a swab + swab stick. If the patient is very nervous a general anaesthetic may be necessary — as well in all cases for children.

4. Epistaxis: is any bleeding from the nostrils. It may be from the nasal cavity, eg. Little's point, or merely serve as an outlet from an injured area behind.

The ~~Emergency~~ first-aid treatment is to seat the patient, make him lean ~~back~~ forward and breathe through his mouth and pinch the ~~part~~ of his nose between his eyes firmly. Cold packs are applied to his forehead + nose and one at the back of the neck; his collar, tie or any constriction around the neck loosened. A kidney dish should be held by the patient, under his nose.

If you lean back a patient with a bleeding nose he will choke as it will go down the back of his throat into his larynx. !!!

If this is unsuccessful the nose should be packed with ribbon gauze soaked in Adrenalin 1:1000 for 5+10 minutes then with hydrogen-peroxide - soaked gauze. Any further bleeding is reported to the Doctor.

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4 (ii) Tray for removal of nasal polypi (sterile)

short + long Thudicum's specula
nasal forceps
packing
Nasal snare
Lee's forceps.
2 kidney dishes
Bowls – swabs (+ gauze ~~etc~~)
– normal saline
– zephiran 1 : 1,000
2 sterile towels.

Mackintosh, cape and towel for patient.
Mackintosh apron, good light and comfortable seat for surgeon
Xylocaine 2% or cocaine if local anaesthetic necessary
Atomiser or de Vilbis spray for L.A.
Cardiac stimulant if cocaine used.
De-congestant drops (Neosynephrine 4% for examination)

Nasal packing is used after operation, most commonly vaseline gauze that is removed after 24hrs.

The post-operative care ~~store~~ is to kept the patient quiet and to rest in bed for a few hours. Any prolonged or excess bleeding is reported, and also any post-nasal discomfort. The patient should be told to breathe through his mouth for a day or two, and not to blow his nose energetically.

Satisfact.

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