Derbyshire Medicines Management, Prescribing and Guidelines
DERBYSHIRE PRIMARY CARE FORMULARY

CHAPTER 12: EAR, NOSE AND OROPHARYNX
Updated: October 2023

The following prescribing guidelines are relevant to the ENT chapter and can be found here:
- Allergic Rhinitis in adults and adolescents over 12 years of age
- Management of chronic rhinosinusitis with or without nasal polyps

12.1 DRUGS ACTING ON THE EAR

12.1.1 Otitis externa

Investigation is not routinely recommended for the initial diagnosis of otitis externa.

Group	Drug
Astringent/acidic preparations	Acetic acid 2% ear spray (EarCalm) *Self-care: patients are advised to purchase this over the counter*
Antibiotic preparations	**Ciprofloxacin 2mg/ml ear drops 0.25ml unit dose PF**
Combined corticosteroid and **aminoglycoside** antibiotic preparations	**Betnesol-N ear/eye/ nose drops*** (Betamethasone 0.1% & neomycin 0.5%)
	Otomize ear spray* (Dexamethasone 0.1%, neomycin 0.5% & acetic acid 2%)
Corticosteroid preparations	**Prednisolone 0.5% ear/eye drops** *Lower potency*
	Betamethasone 0.1% ear/eye/ nose drops *Higher potency*
Antifungal preparations	**Clotrimazole 1% solution 20ml** (with dropper)

* In view of reports of ototoxicity, manufacturers contra-indicate treatment with topical aminoglycosides in patients with a perforated tympanic membrane (eardrum) or patent grommet.

1. How should I treat acute diffuse otitis externa? (CKS)
   - Remove or treat any precipitating or aggravating factors.
   - Recommend OTC simple analgesic for symptomatic relief and apply localised heat (such as a warm flannel) (NICE/PHE).
   - Treat inflammation using a topical ear preparation:
     - Acetic acid 2% (EarCalm) spray for 7 days- can be purchased OTC (age 12 years and over).
     - For more severe cases (pain, deafness, discharge), or if treatment with acetic acid for mild otitis externa is not effective, a topical antibiotic with or without corticosteroid should be used for 7-14 days. Oral analgesics (paracetamol or ibuprofen) for pain.
   - Only consider adding an oral antibiotic for people with severe infection or if the person is immunocompromised, or there is spread beyond the external ear canal.

   Treatment failure
   - Oral antibiotics are rarely indicated. If there are systemic signs of infection or if the infection is spreading outside the ear canal, prescribe a 7 day course of an oral antibiotic (flucloxacillin or clarithromycin if penicillin sensitive; or erythromycin if others contraindicated)
   - If this is ineffective consider the possibility of a fungal infection and treat with topical antifungal such as clotrimazole 1% solution or flumetasone pivalate 0.02%/clioquinol 1% ear drops.

2. Chronic Otitis Externa
   - If mild to moderate fungal infection is suspected (signs of fungal growth in ear canal)
     - A topical antifungal: clotrimazole 1% solution. Apply 2-3 times a day, to be continued for at least 14 days after infection has resolved.
     - Acetic acid 2% spray (unlicenced use) for a maximum of 7 days
     - A topical preparation containing clioquinol and corticosteroid: flumetisone/clioquinol ear drops

- If the cause seems to be seborrhoeic dermatitis treat topically with antifungal-corticosteroid combination
- If no obvious fungal or bacterial infection consider prescribing a topical corticosteroid preparation. If symptoms improve, continue treatment using the lowest potency and/or frequency of application needed to control symptoms.
- Clinoquinol can also be considered as it possesses antibacterial and antifungal activities.
- Seek specialist advice
  - Symptoms persist despite optimal management in primary care
  - Ongoing topical treatment is needed for symptom control beyond 2 or 3 months,.

12.1.2 Otitis media

Acute otitis media is the most common cause of severe aural pain in small children. Most uncomplicated cases resolve without antibacterial treatment and a simple analgesic, such as paracetamol may be sufficient. Advise that the usual course of acute otitis media is about 3 days, but can be up to 1 week. See antimicrobial treatment guideline and NICE NG91.

1. Phenazone with lidocaine (Otigo) ear drops is **GREY** for otitis media. Consider after self-care (simple analgesics) as per NICE NG91. May prevent antimicrobial prescribing. Use only if an immediate oral antibiotic prescription is not given, and there is no eardrum perforation or otorrhoea.
2. Ciprofloxacin 0.3% /dexamethasone 0.1% ear drops can be used for use in children with acute otitis media with tympanostomy tubes(grommets) or tympanic perforation in adults and children over 6months of age.

12.1.3 Removal of ear wax

For treatments of minor conditions such as ear wax patients are encouraged to self-care. Treatments are available to purchase over-the-counter. If self-care not appropriate olive oil (Otadrop Olive oil/ Numark) or sodium bicarbonate 5% ear drops (KliarVax Sodium Bicarbonate/ Sai-Meds Ltd) may be prescribed. For information on management of ear wax see CKS

12.2 DRUGS ACTING ON THE NOSE

12.2.1 Drugs used in nasal allergy

See local guidance, treatment choice for allergic rhinitis should be based on cost.

Beclometasone 50 microgram/dose nasal spray 200 doses — *1st line*
Mometasone 50microgram/dose nasal spray — *1st line*
Budesonide 64 microgram/dose nasal spray — *2nd line*
Fluticasone furoate 27.5 microgram nasal spray (Avamys) — *2nd line*
Fluticasone 400microgram/dose nasal drops
For chronic rhinitis with nasal polyps (step 3) *local guidance*. *Remember to step-down treatment.*

1. Intranasal corticosteroids have similar clinical efficacy.
2. For mild to moderate allergic rhinitis encourage patient to self-care. Treatment can be purchased over the counter e.g., beclometasone or mometasone nasal spray. Use mometasone first line if a prescription is required.
3. Dymista and Ryaltris are combination nasal sprays of fluticasone/azelastine and mometasone/olopatadine, respectively, and are classified locally as **GREY** - for moderate to severe allergic rhinitis (aged 12 years or over) following the Allergic Rhinitis in adults and adolescents over 12 years of age guideline.
4. Sodium chloride 0.9% (normal saline) nasal spray e.g., Aqua Maris, Sterimar are classified as **Do Not Prescribe (DNP)**.

12.2.2 Topical nasal decongestants

For treatments of minor self-limiting conditions such as nasal congestion patients are encouraged to self-care. Treatments are available to purchase over-the-counter. If self-care not appropriate sodium chloride 0.9% nasal drops may be prescribed.

Ipratropium bromide 21microg/dose nasal spray se — *For symptomatic relief of rhinorrhoea in non-allergic rhinitis*

1. Ephedrine & xylometazoline are only suitable for short term use (usually not longer than 7 days) and are available OTC. They are of limited value because they can give rise to rebound congestion on withdrawal, due to a secondary vasodilation with a subsequent temporary increase in nasal congestion.

12.2.3 Nasal preparations for infection

Naseptin cream 15g *For eradication of nasal carriage of staphylococci*

1. Bactroban (mupirocin) only on microbiologist recommendation for decolonisation of MRSA.

12.3 Drugs acting on the oropharynx

12.3.1 Drugs for oral ulceration and inflammation

For treatments of minor, short-term medical conditions such as mouth ulcers, patients are encouraged to self-care. Below treatments can be purchased over the counter from pharmacies.

1. Preparations include hydrocortisone muco-adhesive buccal tablets 2.5mg and benzydamine 0.15% oral rinse.
2. Prednisolone 5mg tablet (local advice- can be crushed and dispersed (off-label)) may be dissolved in 10-20mls of water and used as mouthwash up to 4 times a day for the off-label treatment of oral lichen planus. **Do NOT swallow the contents**. See Patient Information Leaflet https://bisom.org.uk/wp-content/uploads/2020/02/Prednisolone-5mg-soluble-tablets-as-mouthwash-PIL-October-2019.pdf

12.3.2 Oropharyngeal anti-infective drugs

Miconazole 20mg/g oromucosal gel 15g, 80g
Nystatin suspension 30ml

1. Oral fluconazole is effective for unresponsive infections or if a topical antifungal drug cannot be used or if the patient has dry mouth. Topical therapy may not be adequate in immunocompromised patients.
2. For treatments of minor, short-term medical conditions such as oral thrush patients are encouraged to self-care.
3. Miconazole oral gel use in children under 4 months is off-licence because of the risk of choking if not carefully applied, see local guidance on thrush.
4. OTC miconazole oral gel is contraindicated in patients taking warfarin. Patients prescribed miconazole oral gel who are also taking warfarin should be monitored closely and seek immediate medical attention if they experience any sign of bleeding. MHRA September 2017

12.3.3 Lozenges and sprays

There is no convincing evidence that antiseptic lozenges and sprays have a beneficial action and they sometimes irritate and cause sore tongue and sore lips. Some of these preparations also contain local anaesthetics which relieve pain but may cause sensitisation.

12.3.4 Mouthwashes, gargles, and dentifrices

Patients should be advised of self-care measures and signposted to purchase over the counter remedies for dental conditions where appropriate e.g. chlorhexidine gluconate 0.2% mouthwash

1. GPs should not accept requests from dentists to prescribe medicines that the dentist can prescribe themselves.
2. GPs should not accept requests from patients to issue FP10 prescriptions for items prescribed on a private prescription by their dentist during dental treatment as a private patient.
3. Patients should be advised of self-care measures and signposted to purchase over the counter remedies for dental conditions where appropriate

12.3.5 Treatment of dry mouth

Underlying causes of dry mouth such as dehydration, anxiety, infection, or drugs causing dry mouth should be managed if appropriate. Dry mouth may be relieved in many patients by simple measures such as frequent sips of cold unsweetened drinks or sucking pieces of ice or sugar-free fruit pastilles, or chewing sugar-free gum. There are different types of saliva stimulant/ substitute available and patient preference is likely to influence product acceptability and compliance. Below is the most cost-effective preparation from each formulation:

Xerostom saliva substitute *gel, pastilles, mouthwash*
Saliveze *spray*