ENT FINAL — RAPID REVISION

Most Common · Exam Pearls · Key Connections · Clinical Clues

■ EXTERNAL EAR

Condition / Feature	Key Fact
★ **MCC acute diffuse OE**	Pseudomonas aeruginosa
★ **MCC otomycosis**	Aspergillus niger (black dots)
Malignant (necrotizing) OE	Pseudomonas — elderly diabetic ♦ Tx: IV anti-pseudomonal
Treatment otomycosis	Local antifungal × 3 weeks (aural toilet first)
Hematoma auricle Tx	Evacuation + pressure bandage + antibiotics
Cough reflex on ear cleaning	CN X (Vagus) — Arnold's reflex
Referred otalgia nerves	V, VII, IX, X — NOT XII (hypoglossal)
Malignant OE NOT a feature	Mitotic figures — it is NOT malignant tumour, just aggressive infection
Aural toilet irrigation direction	Posterior-superior

■ ACUTE OTITIS MEDIA (AOM)

Feature	Key Fact
★ **MCC AOM (overall)**	Viral (rhinovirus most common virus)
★ **MCC bacterial AOM**	Streptococcus pneumoniae (~45%)
2nd MCC bacterial AOM	H. influenzae
NOT a cause of AOM	Pseudomonas (that's OE) / Dental infection
Route of infection	Eustachian tube (ONLY route)
Bullous myringitis	Viral cause → hemorrhagic blebs on TM
2nd phase AOM — NOT indicated	Topical antibiotics (systemic are used)
★ **MCC intracranial complication**	Meningitis
Earliest intracranial symptom	Headache
Complication: headache + high fever, NO meningism	Epidural abscess

■ CHRONIC OTITIS MEDIA (COM)

Feature	Tubotympanic (Safe)	Atticoantral (Unsafe)
Perforation	Central	Marginal / Attic (NOT central)
Discharge	Profuse, mucoid	Scanty, FOUL-smelling
Cholesteatoma	Absent	PRESENT ★
Treatment	Medical + myringoplasty	SURGICAL always
Danger	Lower	Intracranial complications

COM Extra Pearls	Detail
★ **MCC hearing loss children 3-5y**	Otitis media with effusion (OME/glue ear)
MCC OME (glue ear)	Adenoids
Cholesteatoma =	Growing keratinous pocket — diagnosed by OTOSCOPY
Cholesteatoma pus	Scanty + foul smelling
Traumatic TM perforation — fresh	Watchful observation (most heal spontaneously)

COM Extra Pearls	Detail
Traumatic TM perforation — dry	Protect from water; myringoplasty if no healing
20y female, bad odor discharge, childhood HL	→ CT temporal bone FIRST

■ TINNITUS & VERTIGO

Topic	Key Fact
Objective tinnitus cause ★	Palatal myoclonus (only audible externally)
Subjective tinnitus causes	Meniere's, acoustic neuroma, NIHL, ototoxics, loud noise
Tinnitus Tx — 1st line	Tinnitus retraining therapy (TRT)
Meniere's disease triad	Episodic vertigo + sensorineural HL + tinnitus + aural fullness
★ MCC vertigo (overall)	BPPV — brief, positional, no hearing loss
★ BPPV vs Vestibular neuritis	BPPV: seconds, positional | Neuritis: days, no HL, spontaneous
Vestibular neuritis	Sudden, prolonged (days), NO hearing loss, self-limiting
Labyrinthitis	Like neuritis BUT with hearing loss
Intermediate-duration vertigo	Meniere's disease (minutes-hours)
Vertigo most common age group	Elderly >60 years
Semicircular canals sense	Angular/rotational movement
Utricle & saccule sense	Linear acceleration & gravity

Nystagmus	Peripheral	Central
Direction	Unidirectional, horizontal/rotatory	Multi-directional
Fixation	Suppressed by visual fixation	NOT suppressed
Fatigue	Fatigues (decreases with time) ★	Does NOT fatigue
Latency	Short latency on Hallpike	No latency

■ HEARING LOSS — KEY TABLES

Test	Conductive HL	Sensorineural HL
Rinne	NEGATIVE (BC > AC) ★	Positive (AC > BC, both reduced)
Weber	Lateralises to WORSE ear ★	Lateralises to BETTER ear
AC	Abnormal	Abnormal
BC	Normal ★	Abnormal ★

■ False Negative Rinne: Rinne -ve on left + Weber to RIGHT = severe left SNHL (dead ear), not left CHL
■ Mixed HL: Both AC and BC abnormal, with air-bone gap

Hearing Loss Pearls	Detail
★ MCC acquired SNHL in children	Meningitis
★ 2 most important HL risk factors	Aging + Noise exposure
Presbycusis audiogram	Bilateral high-frequency SNHL, sloping pattern ★
Recruitment =	Cochlear (inner hair cell) pathology
SNHL cause — NOT otosclerosis	Otosclerosis = CONDUCTIVE HL (stapes fixation)
Tympanometry Type A	Normal (midline peak)
Tympanometry Type B (flat)	Fluid in middle ear / TM perforation
Tympanometry Type C	Negative pressure = ET dysfunction
Tympanometry is NOT a hearing test	It tests middle ear compliance ★
Neonatal hearing screen	ABR (Auditory Brainstem Response)
ABR detects	Auditory neuropathy ★
High-risk baby in ICU — highest risk for HL	NICU ≥5 days + aminoglycosides + hyperbilirubinemia
NOT a high-risk factor for HL	Caesarean delivery
Bilateral congenital aural atresia assessment	ABR (can't do PTA)

■ EPISTAXIS & NASAL TRAUMA

Topic	Key Fact
★ **MCC site epistaxis**	Kiesselbach's plexus (Little's area) — 90% of cases
Kiesselbach's plexus supply	Ant. ethmoidal + Sphenopalatine + Greater palatine + Superior labial
NOT supplying Kiesselbach's	Posterior ethmoidal artery ★
Woodruff's plexus supply	Sphenopalatine artery (posterior bleeds)
Active anterior epistaxis — ED 60y	Electrocautery of bleeder (if visible) ★
Posterior packing requires	Hospital admission + monitoring (apnea, hypoxia, arrhythmia)
Epistaxis in children	Mainly inflammation + trauma (NOT tumour/foreign body)
Septal hematoma	Must drain — even small ones (→ avascular necrosis if missed) ★
Nasal trauma reduction timing	Within 2 hrs or 7-10 days window; after 14 days → too late
Post-trauma nasal swelling next day	Think septal hematoma ★

■ RHINITIS — DIFFERENTIAL SNAPSHOT

Type	Key Feature	Diagnosis/Treatment
Allergic rhinitis	IgE-mediated, perennial (dust mite ★) or seasonal	Skin prick test → Tx: AVOIDANCE ★
Vasomotor rhinitis	Non-allergic, non-infectious, 2 types: eosinophilic & non-eosinophilic	Diagnosis of EXCLUSION ★
Atrophic rhinitis (ozena)	Wide nasal cavity, crusting, foul odour, Klebsiella ozaenae	Medical: lubricants + debridement
Rhinitis medicamentosa	Rebound congestion	Caused by OVERUSE of topical decongestants ★
Common cold	MCC acute rhinitis	Viral (rhinovirus)

■ RHINOSINUSITIS

Topic	Key Fact
★ **MCC rhinosinusitis (overall)**	Rhinovirus (viral)
★ **MCC acute BACTERIAL rhinosinusitis**	S. pneumoniae + H. influenzae ★
1st-line antibiotic acute bacterial RS	Amoxicillin-clavulanate (co-amoxiclav) ★
Chronic RS diagnostic criteria (NOT sneezing)	Facial pain, Nasal discharge, Anosmia/hyposmia, Nasal blockage (12 wks)
★ **MCC sinus in children**	Ethmoid (only sinus developed at birth with maxillary)
Sinuses present at birth	Ethmoid + Maxillary ★
Frontal sinus develops by	Age 8+ years
MCC complication ethmoiditis in children	Subperiosteal orbital abscess ★
Nasal polyps origin ★	Anterior ethmoid sinus (most common)
Antrochoanal polyp arises from	Maxillary sinus — usually unilateral, NOT malignant ★
Nasal polyp + asthma + aspirin sensitivity	Samter's triad ★
Best view maxillary sinus	Water's view (X-ray)
Nasolacrimal duct drains into	Inferior meatus ★
Posterior ethmoid drains into	Superior meatus
Foul unilateral nasal discharge	Foreign body ★
Fungal sinusitis suggests	Immunodeficiency
Pain in acute sinusitis	Has diurnal variation ★
NOT a complication of sinusitis	Temporal lobe abscess (it's frontal/parietal)

■ ADENO-TONSILLAR DISEASE

Topic	Key Fact
★ **MCC bacterial tonsillitis**	Group A beta-haemolytic Streptococcus (GAS) ★
★ **MCC tonsillitis (overall)**	VIRAL ★
1st-line antibiotic tonsillitis	Penicillin ★
Adenoids — immunoglobulin production	IgA, IgG, IgD, IgM — all EXCEPT NOT 'Well-developed by age 1' ★
Posterior pillar of pharynx	Palatopharyngeus muscle
Scarlet fever findings	Strawberry tongue + sandpaper rash ★
Koplik's spots	Measles (NOT scarlet fever)
Membranous tonsillitis + hepatosplenomegaly + no response to Abx	Infectious mononucleosis (EBV) ★
Infectious mononucleosis — AVOID	Ampicillin/amoxicillin (causes rash)
Diphtheria caused by	Corynebacterium diphtheriae (bacteria, NOT virus) ★
Quinsy (peritonsillar abscess) Tx	Incision + evacuation + systemic antibiotics ★
Parapharyngeal abscess Tx	External drainage + antibiotics ★
Velopharyngeal insufficiency →	Hypernasality

Tonsillectomy	Absolute Indications	Contraindications
Sleep apnea	✓ ABSOLUTE ★	
Recurrent tonsillitis	✓ Relative (≥7/yr, or 5/yr×2, or 3/yr×3)	
Cleft palate		✗ CI for ADENOIDECTOMY ★
Unilateral hypertrophy (?malignancy)	✓ Absolute	
Rheumatic fever	✓ Absolute	

★ ***Strict indications for tonsillectomy in children exist because: HIGH RISK OF POST-OP BLEEDING*** ★
★ ***Secondary (reactionary) bleeding = 5-10 days post-op (NOT an early complication)***
★ ***Adenoidectomy CI: Cleft palate (causes hypernasality) | Child >10y (adenoids atrophy anyway)***
★ ***Pallatal cleft → most commonly leads to Secretory Otitis Media***

■ PHARYNGITIS DIFFERENTIALS

Condition	Key Clue	Answer
Scarlet fever	Strawberry tongue + sandpaper rash	GAS ★
Inf. mononucleosis	Membranous tonsils + HSM + no Abx response	EBV ★
Diphtheria	Greyish membrane, bull-neck, systemic toxin	C. diphtheriae
Vincent's angina	Ulcerative, foul-smelling, unilateral	Fusospirochaetal
NOT in diff. of follicular tonsillitis	Sarcoidosis ★	Answer: Sarcoidosis

■ STRIDOR & TRACHEOSTOMY

Stridor Type / Location	Key Fact
★ **MCC infant stridor**	Laryngomalacia (omega-shaped epiglottis) — good prognosis ★
Biphasic stridor	Laryngeal web (fixed obstruction) ★
Inspiratory stridor = lesion at	Glottic or supraglottic level ★
Expiratory stridor = lesion at	Tracheal/bronchial level
Newborn: weak cry + hoarseness	Vocal cord palsy ★
Child: fever + stridor + dysphagia	Acute epiglottitis ★ (emergency — do NOT examine throat)
Acute laryngotracheobronchitis (croup) Tx	O2 + humidification + steroids + NO antibiotics ★ (viral)
Laryngomalacia NOT caused by	Epiglottitis (epiglottitis is acquired, not congenital)
★ **MCC unilateral vocal cord paralysis**	Thyroid surgery / iatrogenic ★
★ **MCC vocal cord paralysis (overall)**	Surgical trauma
Bilateral VC paralysis cause	Ca upper oesophagus (compresses both RLNs) ★
NOT a cause of stridor	None — all laryngeal tumours, acute laryngitis, laryngoedema DO cause stridor
Ludwig's angina	Life-threatening floor-of-mouth infection → may need tracheostomy
Tracheostomy NOT indicated for	Unilateral RLN palsy / Severe upper lung atelectasis
Mild stridor management — NOT needed	Tracheostomy ★

■ **Acute epiglottitis: DO NOT examine the throat or lay the child flat → may cause complete obstruction**
■ **Croup (LTB) is VIRAL → antibiotics are NOT part of treatment ★**
■ **Laryngeal trauma → FIRST priority = secure the airway**

■ NECK MASSES — QUICK REFERENCE

Mass / Feature	Key Fact
★ **MCC congenital neck mass**	Thyroglossal duct cyst ★ (midline, moves with swallowing & tongue protrusion)
NOT a midline neck mass	Branchial cleft cyst ★ (lateral)
★ **MCC branchial cyst**	2nd branchial cleft cyst (lateral, anterior SCM)
Dermoid cyst feature	Movable side to side, NOT up-down
Carotid body tumour — biopsy?	NO — highly vascular, biopsy is dangerous ★
Best prognosis malignant parotid	Mucoepidermoid carcinoma ★
Angiofibroma — teenage boy + epistaxis	Rule out with CT (not MRI / not biopsy) ★
Angiofibroma Tx	Surgery (after embolisation to reduce bleeding)

■ HEAD & NECK ONCOLOGY

Nasopharyngeal Ca (NPC)	Key Fact
★ **Most common FIRST presentation**	Cervical lymphadenopathy (unilateral or bilateral neck mass) ★
Other presentations	Epistaxis, nasal obstruction, OME (ear), cranial nerve palsies
★ **MCC unilateral OME in adult**	Suspect NPC ★
MCC site NPC	Fossa of Rosenmuller (lateral nasopharyngeal recess) ★
★ **MCC cranial nerve palsy in NPC**	Abducens nerve (CN VI) — diplopia ★
NPC main treatment	Radiotherapy ★
Post-radiation neck complication	Thyroid carcinoma (years later) ★
NPC + posterior triangle mass + unilateral HL	Classic NPC presentation in exams ★

Laryngeal Tumours	Key Fact
★ **MCC presentation glottic tumour**	Hoarseness (early) ★ — glottis has NO lymphatics → no early nodal spread
★ **Earliest sign supraglottic tumour**	Dysphagia ★
Glottic T1b	Tumour involving BOTH vocal cords ★
Glottic T2	Extension to subglottic or supraglottic area ★
Best prognosis laryngeal tumour	Vocal cord / glottic tumour ★
MCC benign laryngeal tumour in children	Juvenile papilloma (HPV) ★
Diagnosis laryngeal tumour	Direct laryngoscopy ★ (NOT flexible scope alone)
Singer's nodule location	Vocal cords (junction ant. 1/3 + post. 2/3) ★

Head & Neck SCC & Neck Mets	Key Fact
★ **MCC primary malignant neck tumour**	Squamous cell carcinoma ★
Hidden primary SCC sites	Base of tongue, tonsils, pyriform sinus, supraglottic larynx
NOT a hidden primary site	Vocal cords (glottis presents early with hoarseness) ★
FNA → metastatic SCC neck	Next step: Pan-endoscopy (find the primary) ★
MCC metastasis to cervical LN	Nasopharyngeal carcinoma / Tonsils ★
Early pyriform fossa tumour presents with	Referred otalgia ★
Tumours that stay SILENT longest	Piriform fossa, oesophageal — NOT vocal cord ★
Zenker's diverticulum	Elderly + regurgitation of undigested food ★
Oesophageal FB — most fatal complication	Mediastinitis ★
Mass at foramen caecum — first do	Thyroid scan (may be ectopic thyroid) ★
Eustachian tube length	2.5 cm; opens by tensor palati (NOT levator)
Bell's palsy treatment	Steroids (NOT surgery) ★

■ MASTER 'MOST COMMON' CHEAT SHEET

Topic / 'Most Common'	Answer
★ MCC acute diffuse OE	Pseudomonas aeruginosa
★ MCC otomycosis	Aspergillus niger
★ MCC AOM (overall)	Viral
★ MCC bacterial AOM	S. pneumoniae
★ MCC intracranial complication AOM/COM	Meningitis
★ MCC HL in children 3-5y	OME (glue ear / secretory OM)
★ MCC cause OME	Adenoid hypertrophy
★ MCC acquired SNHL in children	Meningitis
★ MCC vertigo	BPPV
★ MCC epistaxis site	Kiesselbach's plexus (90%)
★ MCC rhinosinusitis	Rhinovirus
★ MCC acute BACTERIAL sinusitis	S. pneumoniae + H. influenzae
★ MCC sinus infected in children	Ethmoid
★ MCC complication ethmoiditis children	Subperiosteal orbital abscess
★ Sinus present at birth	Ethmoid + Maxillary
★ MCC bacterial tonsillitis	Group A beta-haemolytic Streptococcus
★ MCC tonsillitis overall	Viral
★ MCC infant stridor	Laryngomalacia
★ MCC unilateral VC paralysis	Thyroid surgery
★ MCC VC paralysis overall	Surgical trauma
★ MCC congenital neck mass	Thyroglossal duct cyst
★ MCC primary malignant neck tumour	Squamous cell carcinoma
★ First presentation NPC	Cervical lymphadenopathy
★ MCC site NPC	Fossa of Rosenmuller
★ MCC CN palsy NPC	Abducens (CN VI)
★ MCC glottic tumour presentation	Hoarseness
★ Earliest sign supraglottic tumour	Dysphagia
★ MCC silent tumour	Piriform fossa / Oesophageal
★ MCC perennial allergy (Jordan)	Dust mite
★ MCC nasal polyp origin	Anterior ethmoid sinus

★ KEY CONNECTIONS: Pseudomonas → OE malignant (elderly diabetic) | Eustachian tube → AOM route | Adenoids → OME/glue ear
★ CLINICAL CLUE: Foul + scanty discharge = cholesteatoma ★ | Foul unilateral nasal discharge = foreign body ★
★ CLUE: Unilateral OME in adult = NPC until proven otherwise ★ | Teenage boy + epistaxis = angiofibroma ★
★ NEVER forget: Tympanometry is NOT a hearing test (middle ear compliance only) ★
★ ALWAYS: Cleft palate = CI for adenoidectomy ★ | NPC Tx = radiotherapy ★ | Acute LTB = NO antibiotics ★