These are the initial pages of different chapters of the book. For further reading, kindly refer the book.

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HISTORY TAKING IN E.N.T.

1. **NAME**: Name is asked -
   - For the identification of the patient.
   - For developing rapport with the patient.
   - For maintaining the record of the patient.

2. **AGE**: Certain diseases are common in certain age groups like -
   - Presbyacusis is common in old age *(it is the condition in which bilateral high frequency sensorineural hearing loss occurs.)*
   - Atrophic rhinitis and otosclerosis are more common at puberty.

3. **SEX**: Certain diseases are common in particular sex like -
   - Juvenile nasopharyngeal angiofibroma (JNAF) is exclusively found in males.
   - Atrophic rhinitis and otosclerosis are more common in females. *(Otosclerosis causes ankylosis of footplate of stapes and causes conductive deafness and tinnitus. It is treated medically by sodium fluoride and surgically by stapedectomy.)*

4. **CASTE**: Certain castes have certain type of diseases like -
   - Bodhya community (Mahar) of Vidarbha region of India has more incidence of sickle cell anæmia, hence epistaxis is more common.
   - Sindhis have more incidence of thalassemia major & have more episodes of epistaxis and bleeding disorder.

5. **RELIGION**: Because of consanguinious marriage in Muslims, the incidence of congenital sensorineural deafness is more.

6. **OCCUPATION**:
   - Vocal nodules are more common in hawkers and in children who scream a lot.
Practical E.N.T.

Septal perforation is more common in nickel, chromium and arsenic workers.

Sensorineural hearing loss (specially at 4000 Hz) is more common in people who are exposed to constant loud noise like mill workers, persons staying near railway tracks or airport.

Laryngocele was believed to be more common in trumpet blowers and glass workers.

*(Laryngocele is the enlargement of saccule. It may be of external, internal or mixed variety.)*

7. ADDRESS: Certain diseases have more geographical predilection -

- Rhinosporidiosis is very common in Jharkhand, Chattisgarh, Madhya Pradesh and West Bengal states of India. The earlier belief of scleroma line which states that if a horizontal line is drawn from Mumbai to Vishakhapatnam, the area above has more incidence of rhinoscleroma and the area below has more incidence of rhinosporidiosis is not very accepted.

  - *Rhinoscleroma is a progressive granulomatous disease caused by Klebsiella rhinoscleromatis. Histologically it has Mikulicz cell containing Frisch bacilli. The end result of this disease is painless stenosis of vestibule and nose. It is treated by the surgical excision of stenotic lesion.*

  - *Rhinosporidiosis is a fungal infection caused by the Rhinosporidium seeberi and kinealyi. It is more common in those who take bath in pond where cattles also have bath. It spreads by the dust from the dung of infected cows and cattle. The treatment is surgical excision.*

- Plummer Vinson syndrome is very common in central part of Gujarat.

  *Plummer Vinson syndrome consists of dysphagia, hypochromic microcytic anaemia, glossitis, angular stomatitis and koilonychia. The complication of this syndrome is postcricoid web formation.*

8. PAST HISTORY: Enquire about previous history of -

- Diseases like diabetes, tuberculosis and hypertension. All these may have bearing on the present state of disease like in untreated or active tuberculosis there may be associated tuberculous otitis media or laryngeal tuberculosis. In untreated or uncontrolled diabetes, the chances of infection are very high.
Drugs - Certain drugs are toxic to ear like streptomycin is vestibulotoxic while dihydro-streptomycin is cochleotoxic. Quinine or salicylates cause tinnitus in the ear.

Postnatal jaundice may cause deafness due to the deposition of conjugated bilirubin in brain stem nuclei.

Head injury- Fracture of cribriform plate may cause anosmia or C.S.F. rhinorrhoea. Fracture of temporal bone may cause deafness, facial nerve palsy or C.S.F. otorrhoea.

9. PERSONAL HISTORY:
- Smoking may lead to carcinoma larynx.
- Tobacco and ‘Gutkha’ chewing may cause carcinoma of oral cavity and oral submucus fibrosis (OSMF).
- Postcricoid carcinoma is more common in cigar smokers.
- Senile degenerative changes of inner ear are early in heavy smokers and heavy alcoholics.

10. FAMILY HISTORY: To know the hereditary cause of deafness like -
- Otosclerosis is an autosomal dominant disease.
- Congenital sensorineural deafness in children is directly related with Mendelian law.

Mendelian law states that when two hybrid (people with normal hearing but carrying deafness) marry, then deaf children must follow.

11. SOCIAL HISTORY: Unsafe sexual contact may lead to AIDS
(Hairy leucoplakia of oral cavity is highly suggestive of AIDS).

12. GENERAL EXAMINATION:
- Examine pulse, blood pressure, cyanosis, clubbing, anaemia, jaundice and the lymph nodes.
- Hypertension may cause epistaxis, cyanosis is present in advanced laryngeal and bronchial malignancy, clubbing is present in bronchial carcinoma and anaemia is present in recurrent epistaxis.
Examination of lymph nodes - Make the patient comfortably seated on the chair and examiner stands behind the patient, flex the neck of the patient slightly and start palpating on both sides systematically and symmetrically, starting with submental, submandibular, jugulo-digastric, jugulo-omohyoid, preauricular, postauricular, occipital, and the vertical chain of lymph nodes at carotid region etc. Palpate on both the sides of neck even if lesion is unilateral.
HISTORY & EXAMINATION OF EAR

COMPLAINTS

Complaints are being recorded in the chronological order i.e. the complaint, which occurred first, should be recorded first, the subsequent complaints next in the descending order.

For example:
- Ear discharge for last 2 years,
- Deafness for last 1 year,
- Vertigo for 8 months,
- Pain, headache for 4 months,
- Ringing in the ear for 15 days,
- Facial asymmetry for 5 days.

The complaints should be recorded in that order only, as discharge was the first complaint so it should be recorded first followed by deafness, vertigo, pain, headache and so on.

HISTORY OF PRESENTING ILLNESS

(i) Discharge
(ii) Deafness
(iii) Vertigo
(iv) Pain
(v) Tinnitus
(vi) Autophony
(vii) Facial nerve palsy
(viii) Fever
(ix) Headache

(i) Discharge: Following points are to be observed:

1. Smell:
   - Foul smelling discharge indicates unsafe otitis media (suspicion of cholesteatoma). Safe otitis media can also have foul smelling discharge if it is secondarily infected.
   - Non-foul smelling discharge indicates safe type of otitis media.
2. **Consistency:**
   - If discharge forms a string, it indicates the discharge from the middle ear as mucus secretory glands (Goblet cells) are present only in the middle ear.
   - If discharge is non-string forming it indicates discharge from the external ear, as no mucus secretory glands are present in the external ear. This discharge may be due to furunculosis or rarely from the parotid abscess.

3. **Colour:**
   - The normal colour of pus is creamish yellow. In pseudomonas infection it is greenish in colour.

4. **Blood Stained Discharge:**
   - In tubotympanic type disease, the discharge is not blood stained. If it is blood stained, it indicates presence of granulation tissue in the middle ear, which is more common in atticoantral type of otitis media. The blood stained discharge may also present in underlying malignancy.

5. **Watery Discharge:**
   - Clear watery discharge occurs in C.S.F. otorrhoea.

6. **Quantity:**
   - Scanty discharge indicates atticoantral type of disease while moderate to profuse discharge points towards tubotympanic type of otitis media.
     - Profuse Discharge: If discharge comes out of ear canal and stains the pillow during sleep.
     - Moderate Discharge: If discharge remains in the external auditory canal.
     - Scanty Discharge: If the tip of swab stick is stained by the discharge.

7. **Active / Inactive / Quiescent Stage of Discharge:**
   - Active Stage: If discharge is present.
   - Inactive Stage: If discharge is not present for minimum 3 to 6 weeks.
   - Quiescent Stage: If discharge is absent for a few days, but reappears in-between and again.
(ii) Deafness: Following points are to be observed:

1. Sudden or Gradual Deafness: Gradual deafness occurs in C.S.O.M. while sudden deafness occurs in viral diseases or in fracture of the temporal bone.

2. Degree of Deafness: Mild, moderate or severe type of deafness. (Details can be found in the tuning fork test)

3. Fluctuation of Deafness: Fluctuating deafness occurs in secretory otitis media as different head position causes difference in deafness specially when fluid is thin. Hearing is usually better in supine position when patient is lying on the bed but alters on getting up (erect position). Fluctuation of deafness also occurs in Meniere’s disease and in perilymph fistula.

4. Deafness at the Time of Discharge: Does deafness increases or decreases at the time of discharge? Usually at the time of discharge deafness should increase as it means flare-up of disease. But in case of ossicular disruption, discharging fluid inside the middle ear causes good medium for the sound transmission and patient may find improvement of hearing at the time of discharge.

5. Deafness at Crowded Place: In otosclerosis, patient hears better in the crowded place, this is called Paracusis Willisii.

6. Distortion of Sound: Sound is heard at different pitch in the affected ear. It is called diplacusis and occurs in Meniere’s disease.

7. Alteration of Deafness with Vertigo: In Meniere’s disease before the onset of vertigo, deafness increases but returns to normal after the attack of vertigo. But with every subsequent attack of vertigo, hearing deteriorates and deafness increases (which is of sensorineural type).

(iii) Vertigo: It is the false sense of orientation.

Following points are to be observed:

1. Presence or Absence of Vertigo: Presence of vertigo with ear discharge indicates intracranial or threatening intracranial complications.

2. Types of Vertigo: Patient himself is moving, the surrounding is moving, sense of unsteadiness, sensation of to-and-fro, up-and-down movement or falling off suddenly (known as “drop attacks” or “utricular crises”). All these types of vertigo are present in Meniere’s disease.
EXAMINATION OF NECK
(Excluding the Thyroid Gland)

HISTORY

- Branchial fistula is congenital and present since birth.
- Branchial sinus and cystic hygroma although congenital but present only when child has grown-up.
- Inflammatory swellings may occur at any age.
- Secondary carcinoma occurs more commonly in old age.
- Submandibular salivary gland calculus has history of increase in size of swelling in the submandibular triangle during meal.

LOCAL EXAMINATION

Inspection

(i) Swelling:

- Examine its site, size, shape and surface etc. like any other swelling.
- Branchial cyst is situated at the upper part of neck and the posterior part of swelling is under cover of upper third of sternomastoid muscle.
- Carotid body tumour lies under the anterior margin of sternomastoid muscle at the level of upper border of thyroid cartilage (at the level of bifurcation of common carotid artery).
- Aneurysm is a pulsating swelling in the line of carotid artery.
- Sternomastoid tumour is an oval swelling of the sternomastoid muscle in the newborn.
- Dermoid cyst occurs in the midline of neck more commonly in the lower part - ‘Space of Burns’.

(Space of Burn is a narrow interval between the deep and superficial layers of the cervical fascia above the manubrium sterni through which pass the anterior jugular vein).
Examination of Neck

- Cystic hygroma is in the lower part of posterior triangle. (Cervical rib also shows prominence at this site.)
- Multiple lymph nodes on both the sides are common in the posterior triangle.
- Ask patient to swallow the saliva - Thyroid-swelling and thyroglossal cyst moves with deglutition but thyroglossal cyst moves up also with protrusion of tongue.

(ii) Skin

- Redness and oedema of skin suggests inflammation.
- Tuberculous sinus or fistula is due to bursting of caseous lymph nodes.
- Branchial fistula is commonly seen at lower third of anterior border of sternomastoid.

Palpation

Ask patient to flex the neck and turn slightly towards the side which is to be examined in order to relax the muscles and fascia.

(i) Swelling:

Examine its site, size, shape, surface, margin, consistency, reducibility, impulse on coughing and mobility like in any other swelling.

- Examine the swelling in relationship with sternomastoid muscle.
  - On one side- by keeping your hand against the chin opposite to the site of swelling and ask patient to press against the resistance.
  - On both sides- ask patient to press the chin against the resistance where both the sternomastoid muscles come into the action.
- If swelling is beneath the sternomastoid which is quite often, swelling disappears. If swelling is superficial to muscle, it becomes prominent.
EXAMINATION OF THYROID GLAND

HISTORY

➢ Physiological goitre occurs in girls at puberty.
➢ Hashimoto’s disease occurs in women who have just passed the menopause.
➢ Usually goitre is painless condition. Sudden increase in size with pain indicates haemorrhage within the goitre.
➢ Enquire about pressure effects - pressure on
  - trachea causes dyspnoea,
  - oesophagus causing dysphagia
  - recurrent laryngeal nerve causing hoarseness of voice.

GENERAL EXAMINATION

Look for excitability, trembling, nervousness, sweating, wasting etc.

LOCAL EXAMINATION

Inspection

1. Position: The normal thyroid consists of two lateral lobes joined together by a central isthmus, which overlies the second and third tracheal rings.

2. Size: The normal thyroid is palpable in about 25% of men and 50% of women. Consider goitre if the lateral lobes of thyroid gland have a volume in excess of that of terminal phalanx of the thumb of the patient.

3. Shape: The gland is usually symmetrical in primary hyperthyroidism, while it is irregular in secondary or nodular toxic goitre.

4. Overlying Skin: The colour changes over goitre are unusual unless it is very big, the distended veins may be responsible for dusky blue appearance.

5. Surface, Pulsation etc. are to be inspected.

6. Mobility: Ask patient to swallow, thyroid swelling moves upwards on
swallowing (as thyroid gland is ensheathed by the pretracheal fascia). Other swellings like subhyoid bursitis, prelaryngeal and pretracheal lymph nodes also move with deglutition as they are fixed to hyoid, larynx or trachea.

In retrosternal goitre, pressure on the great veins at the thoracic inlet gives rise to dilatation of subcutaneous veins over upper anterior part of thorax (Pemberton’s sign.). Ask patient to raise both arms for sometime touching the ear. In retrosternal goitre there is congestion of face, cyanosis, and distress due to obstruction to the great veins at the thoracic inlet.

**Thyroglossal Fistula**: It is seen near the midline a little below the hyoid bone. The opening of fistula is indrawn and covered by a crescent fold of skin

**Thyroglossal Cyst**: It moves up with protrusion of tongue as thyroglossal duct extends from foramen caecum of the tongue to the isthmus of thyroid gland.

**Palpation**

The thyroid gland should be palpated from the front and from the behind with the patient’s neck slightly flexed. The patient is asked to swallow during the palpation. Any enlargement of thyroid gland or any nodule is appreciated by placing the thumb on the thyroid gland during the swallowing (as by Crile jr.)

Palpation of each lobe is carried out by Lahey’s method in which examiner stands in front of patient and in order to palpate the right lobe, the thyroid gland is pushed to the right from the left side. The lobe is thus made prominent and palpated with the other hand.

During the palpation observe the position, extent shape, etc. of the swelling.
This book is very good for undergraduates and postgraduates for history taking and clinical examination. There was genuine need for such type of book in E.N.T.

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This book is truly practical, unique, and to the point. This is best practical guide to ENT residents and specialists I have ever seen. The style is so unique, that it vividly represents a thorough bedside teaching from the master. I really believe that one can get the core of ENT, which can not be attainable from heavy-volume Western textbooks.

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"Professor Sinha is a well-known ENT specialist who is traveling a lot to Asia and Europe to enlarge his knowledge and experience in the latest knowledge of E.N.T. His focus is specifically on teaching the younger colleagues and this book is ideal for this. It presents the latest standards of ENT in history taking, diagnosis and treatment. I congratulate Professor Sinha for this excellent book and hope it will be widely spread and used. Not only every M.B.B.S. students but M.S. students will also find in this book a good comprehension of ENT diseases. I wish this book a great success. All the best from Stuttgart."

Prof. Dr. med. Wolfgang Gubisch
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"Practical E.N.T." book has elegantly captured the essence of ENT. It’s very comprehensive and well written. The clinical history and examination has been very well written with additional clinical points that will make it very clear and easy to understand. I am sure that this book will truly benefit every reader, whichever level he or she may be. My compliments to Dr Vikas Sinha for this excellent work."

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The author has made commendable effort to simplify and present a wealth of clinical information on Otorhinolaryngology in one source. The general and specific clinical information offered is going to be useful for all who desires a comprehensive understanding on the subject. The book will be of immense help to the otorhinolaryngologists especially for the medical students to sharpen their clinical acumen. This book is highly recommended to the medical students.

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