York Teaching Hospital NHS Foundation Trust

YORK TEACHING HOSPITALS NHS FOUNDATION TRUST

GP DIRECT ACCESS GUIDANCE FOR HEAD AND NECK US

Introduction

Ultrasound (US) can be very useful as a first line investigation. It is typically non-invasive and does not involve ionising radiation. However, a significant number of requests are received where ultrasound is very unlikely to be helpful; this prolongs waiting times for all and can even delay some patients from being referred for a more appropriate test, thereby delaying their diagnosis.

If you aren't sure if ultrasound will change your patient's management please email RadiologyAdvice&guid@York.NHS.uk for advice and your query will be passed on to an appropriate subspecialty radiologist.

To support the radiologist/sonographer perform an optimal examination, it would be helpful to include the following details when appropriate.

- Presenting symptoms
- Requests should include a specific clinical question(s) to answer
- Findings on clinical examination
- Results of any other relevant investigations
- Relevant past history
- Differential diagnosis

The majority of US examinations are now performed by sonographers and not doctors. Suspected diagnosis must be clearly stated, not implied by vague, non-specific terms such as 'pain query cause' or '? Pathology' etc.

Please understand that our aim is to make the best use of the resource available to us to provide the best outcome for your patient and not hinder good quality care for others.

This document has been compiled by sonographers, GP's and radiologists to support good practice in vetting and justifying referrals for ultrasound examinations. This guidance is based on clinical experience supported by peer reviewed guidance from the British Medical Ultrasound Society.

The document contains sections on Neck Pain/Discomfort and Swelling Thyroid, Throat, and Other areas

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	NECK DISCOMFORT/PAIN & SWELLING	
Indication	**Advice**	**Justified?**
Posterior and Lateral Neck Pain	US is not indicated for assessment of musculoskeletal neck pain. Referral to community MSK if required.	NO
TMJ pain/clicking	US not indicated. Advise TMJ rest – avoid wide opening and chewing gum; soft diet; analgesia. If persistent (>3 months) refer to general dental practitioner or Max fax.	NO
Skin Lesion and Lesions attached to skin	US has **NO ROLE** in the diagnosis of small lesions of cutaneous appendages and dermatological lesions. If clinical concern, refer to Dermatology, initially via Advice and Guidance with attached photos.	NO
Lymph nodes	**Palpable small mobile lymph node or nodes in a <u>child or young adult who is otherwise healthy</u>** Patient needs to be **physically examined** by clinician prior to referral. A good clinician checks for nodes elsewhere... in the neck, axilla, groin, liver, spleen. Manage according to these findings. US not indicated. Reassure patient. Small mobile nodes can persist indefinitely and be simply normal palpable lymph nodes (pea-sized lumps) are commonly felt in the posterior triangles.	NO
	Where there is a palpable or visible neck lump with Red Flag signs and concern about malignancy **Use 2WW referral** to ENT or MaxFax as clinically appropriate. They will organise the US if thought necessary from the referral details.	YES <u>by Secondary Care</u>
	Palpable or visible swelling with signs of local sepsis Treat with antibiotics. If around the jaw, consider dental assessment and dental radiographs as appropriate. Consider referral to Dentist or MaxFax.	NO

Salivary swelling	**Mealtime swelling** Requires ultrasound (ideally with sialogogue). **Persistent salivary swelling** US cannot reliably differentiate benign from malignant lesions. US and a MaxFax referral is required.	YES
Swelling behind angle of Mandible	**Unilateral persistent swelling** Threshold for scanning swelling behind mandible should be low as it may be due to parotid tumour, lymph node or branchial cyst.	YES
	Bilateral intermittent swelling Intermittent swelling is usually due to reactive nodes. US is ONLY indicated via **2WW pathway** if persistent (>6 weeks) or progressively enlarging. The presence of tenderness and intermittent swelling points to inflammatory/infective causes of cervical lymphadenopathy rather than malignancy. Examination of the axillae and groin nodes and consideration of a viral panel/Monospot test should be considered.	MAYBE by Secondary Care
Facial and cheek swelling	**Post Prandial swelling** US (ideally with sialogogue) is recommended.	YES
Intraoral Swelling	Intraoral swelling, white patch or ulceration that persists for >6 weeks requires Maxfax referral.	NO
Sternoclavicular joint swelling	This is usually due to osteoarthritis and is more pronounced on the dominant handed side. US has little role in the diagnosis. If thought to be an inflammatory arthropathy, refer to rheumatology.	NO

	THYROID	
Indication	**Advice**	**Justified?**
Hyperthyroidism	Refer to Endocrinologist. US is not first line but used with nuclear medicine (only via specialist referral). See RCP guidelines	NO
Hypothyroidism	US Imaging is not indicated. If palpable lump refer via **2WW Pathway to ENT**	NO
Hyperparathyroidism and hypercalcaemia	Hypercalcaemia with detectable or raised PTH is most commonly caused by primary hyperparathyroidism but there are other possible causes. Formal assessment by an endocrinologist is recommended. Imaging is only indicated in patients who have biochemically proven PRIMARY hyperparathyroidism as part of a localisation procedure IF they are surgical candidates. (i.e. only via specialist referral)	NO
Thyroid Swelling	**Sudden onset thyroid swelling especially if <40 years old.** This is usually due to haemorrhage into a benign thyroid nodule or cyst. Routine US can confirm diagnosis. **Rapidly enlarging swelling especially if >40 years old** Patients >40 years should be referred for an **urgent US** by the GP. Thyroid nodules are common especially in females >50 years. The vast majority will be benign. US can categorise these using the British Thyroid Association criteria (e.g.BTA U3 and above will require tissue sampling). Radiology will make clear in the report if onward referral to the thyroid MDT is required. **New thyroid swelling +/- palpable enlarged lymph nodes** If any Red flag signs (hard swelling, palpable nodes, family history, childhood radiation exposure) refer to thyroid clinic under **2WW pathway**	YES YES YES
	Gradually increasing thyroid swelling This is usually due to a benign goitre but a small proportion could have a malignant nodule. It is the natural history of benign nodules to grow over time so if the patient has previously had a thyroid US showing benign nodules it may be appropriate to observe clinically. If there is a concern for compressive symptoms, an ENT referral would be more appropriate.	MAYBE

	THROAT	
Indication	**Advice**	**Justified?**
Globus (sensation of lump in throat)	Globus is usually a benign symptom. US is not helpful. If symptoms are troublesome & persistent (> 6 weeks), referral to ENT should be considered.	NO
Throat discomfort	Most throat pain is transient and resolves spontaneously. US is not helpful. Persistent discomfort (>6 weeks) requires ENT referral.	NO
Dysphagia (True difficulty in swallowing)	Dysphagia is a **RED FLAG** symptom and US generally not indicated. Refer to ENT for High dysphagia and UGI for Low dysphagia under **2WW pathway**	NO
Hoarse Voice	Enlarged palpable thyroid nodule If thyroid cancer suspected, specialist referral to thyroid clinic, under **2WW pathway**. If longstanding goitre, routine ultrasound referral	YES
	No definite thyroid enlargement US is NOT indicated. Refer patient to ENT. Unexplained and persisting hoarseness for >6 weeks is an indication for a **2WW ENT referral**	NO
	OTHER	
Indication	**Advice**	**Justified?**
Dry Mouth	If you are concerned for Sjogren's syndrome, refer to MaxFax on a routine basis. Check CRP and autoantibody screen (RhF, ANA specifically Anti Ro (SS A) and Anti la (SS B) antibodies prior to referral.	NO
Follow-up of known conditions	It is the natural history of many benign conditions (goitre, lipoma) to slowly enlarge and routine US follow-up is not required. A small, progressive size change is **not** an indication for F/U. It is the natural history of lipomata to grow slowly over time – a sudden increase in size or pain is concerning and would necessitate fast track US.	MAYBE