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Headlamp Ear Nose Throat and Neck Examination

Practical 01 / Supervised clinical examination

Aim

Elicit an ENT history and demonstrate a focused external and anterior examination.

Principle

Laterality, time course and symptom combinations guide examination. Appropriate lighting, positioning and gentle inspection improve visualisation.

Materials and Requirements

- Consenting volunteer or simulator, headlamp and tongue depressor
- Nasal speculum trainer and neck model

Procedure

1. Ask about symptoms, laterality, duration, hearing or smell changes, discharge, voice and swallowing. Screen for airway or other urgent concerns.
2. Seat the patient upright in good light if stable. Verify identity, permission, affected side and any pain, then check that the headlamp illuminates the intended field before contact.
3. Inspect external ears and nose and use the approved headlamp position. Observe anterior nasal structures and state septal and mucosal findings as taught.

Continue with step 4 on the next page.

Procedure Continued

Headlamp Ear Nose Throat and Neck Examination

4. Compare both pinnae, canal entrances and adjacent skin. Inspect the external nose and front of each nostril on the model or under supervision and identify septum, mucosa and visible discharge.
5. Position the approved instrument under direct vision and support the hand. Pause with pain or restricted view and record which nasal areas were visible and why the examination was limited.
6. With consent inspect the mouth, tonsillar areas and visible pharynx and examine relevant neck regions and nodes gently.
7. Use suitable lighting to inspect lips, tongue, palate, tonsils and visible pharynx. Compare side and symmetry, then examine the appropriate cervical node groups with gentle palpation.
8. Document findings and suggest the targeted test or supervised referral for the remaining question.
9. Present each region and side in order, including visible changes and areas not examined. Relate the chief concern to one focused investigation or referral under the supervising team.

Precautions

- Use the smallest appropriate examination scope and stop for pain or distress.
- Escalate stridor or inability to handle secretions immediately.

Observations and Interpretation

Headlamp Ear Nose Throat and Neck Examination

Observations and Record

Item	What to record	What it tells you
ENT history	Time course, side and functional impact	Prioritises examination
Anterior assessment	Site, symmetry and visible anatomy	Provides localised findings
Neck and next step	Nodes or masses and escalation	Supports a focused handover

Worked Example

A record of persistent hoarseness with a new neck lump warrants supervised specialist assessment. Record both findings and when each began.

Result and Interpretation

Present a side-specific examination and one justified follow-up investigation or referral question.

Viva Questions and Answers

Why use a headlamp?

It directs light along the examiner's view while leaving hands available.

Why ask localization and duration?

They shape examination and urgency.

Otoscopy and Tympanic Membrane Diagram

Practical 02 / Supervised clinical examination

Aim

Demonstrate gentle otoscopy and sketch a side-specific tympanic membrane finding.

Principle

The canal and tympanic membrane should be described separately. Visual landmarks and membrane position, integrity and mobility provide complementary information.

Materials and Requirements

- Clean otoscope with appropriate specula
- Ear trainer and supplied pneumatic otoscopy or microscopy records

Procedure

1. Confirm consent and side and inspect the pinna and canal entrance before using the otoscope.
2. Check pain, discharge, hearing change, prior procedures and known perforation. Inspect pinna, mastoid area and canal entry under direct light and explain the examination.
3. Choose a suitable clean speculum. Practise safe hand bracing and canal alignment on the model or supervised volunteer.
4. Test the lamp, choose the largest comfortable clean tip for the model and brace the examining hand against the head or model. Align the canal with the age-appropriate method taught by faculty.

Continue with step 5 on the next page.

Procedure Continued

Otoscopy and Tympanic Membrane Diagram

5. Advance only under direct vision sufficiently to view the canal and membrane and stop if resistance, pain or unexpected movement occurs. Compare the other ear when appropriate.
6. Identify canal, membrane, malleus and position of observed changes. Review a model or recording for mobility assessment when appropriate.
7. Identify the malleus and umbo, pars tensa and pars flaccida if visible. Describe colour, contour, integrity and the location of a finding and assess mobility only in the approved demonstration.
8. Draw a labelled membrane with side and quadrants and record limits such as wax or incomplete visualisation.
9. Sketch four quadrants on the correctly sided diagram. Add orientation and visible landmarks and mark wax, incomplete views or other reasons confidence is limited.

Precautions

- Do not advance against pain or resistance.
- Practise pneumatic techniques and instrumentation only in the approved teaching setup.

Observations and Interpretation

Otoscopy and Tympanic Membrane Diagram

Observations and Record

Item	What to record	What it tells you
Canal	Patency, inflammation, wax and visualisation	Distinguishes external and middle-ear clues
Membrane	Landmarks, integrity and position	Supports localised description
Mobility	Observation or record under approved method	Adds information about membrane movement

Worked Example

An image shows a retracted membrane but little of the canal is seen. Record what is visible and what is obscured before suggesting a middle-ear assessment.

Result and Interpretation

Give a clear side-specific report and diagram. State if the membrane was incompletely seen.

Viva Questions and Answers

Why brace the examining hand?

It helps prevent sudden relative movement between the otoscope and ear.

What does membrane mobility add?

It helps assess middle-ear mechanics when measured under appropriate conditions.

Tuning Fork Tests and Audiogram Interpretation

Practical 03 / Supervised clinical examination

Aim

Demonstrate Rinne and Weber on a suitable volunteer and interpret air and bone thresholds and tympanometry.

Principle

Air conduction uses external, middle and inner ear pathways. Bone conduction bypasses much of the outer and middle ear. The pattern, method and masking determine the supported interpretation.

Materials and Requirements

- 512 Hz tuning fork and quiet room
- Supplied labelled audiograms and tympanograms

Procedure

1. Check symptoms and side. Compare bone and air perception on each side using the taught Rinne method.
2. Check which ear is affected and explain the comparison in a quiet room. Use the course's tuning fork, commonly 512 Hz, and verify that the person understands the response task.
3. For each Rinne test compare perception at the mastoid and by the canal using the taught sequence while the fork is vibrating. Record air louder than bone, bone louder than air or unclear.
4. Place the vibrating fork at an appropriate midline point for Weber and ask whether sound is heard centrally or on one side.

Continue with step 5 on the next page.

Procedure Continued

Tuning Fork Tests and Audiogram Interpretation

5. Centre the base over the reference midline point and ask an open question about where the sound seems louder. Check answer consistency and interpret Weber with both Rinne findings.
6. Confirm audiogram symbols, units, masking and applicable air and bone thresholds. Identify a supported gap and review the accompanying tympanogram.
7. Read the audiogram frequency and dB HL axes, separating the two ears and air from bone symbols. Check masking and compare air and bone thresholds at the same frequencies.
8. Review the tympanogram shape and accompanying ear-canal volume before making an inference. Describe whether the available results support conductive, sensorineural or a mixed pattern.
9. Reconcile the findings with history and document limitations, particularly severe unilateral loss or an unclear response.
10. State the side, evidence and unresolved questions. Refer sudden hearing loss or inconsistent tests for senior assessment and formal audiological review.

Precautions

- Use calibrated reported results to grade loss.
- Sudden hearing loss or other red flags need timely assessment through the clinical pathway.

Observations and Interpretation

Tuning Fork Tests and Audiogram Interpretation

Observations and Record

Item	What to record	What it tells you
Rinne and Weber	Side, relative air and bone response and lateralisation	Provides screening clues
Audiogram	Thresholds and air-bone gap at defined frequencies	Describes hearing type and extent
Tympanometry	Pattern and ear canal volume where appropriate	Adds middle-ear evidence

Worked Example

In an illustrative right ear, air threshold is 40 dB HL and bone threshold is 10 dB HL at one frequency. The 30 dB gap supports a conductive component if other audiometric and masking evidence agree.

Result and Interpretation

State the supported hearing pattern and what the full audiology assessment should clarify.

Viva Questions and Answers

What does air louder than bone suggest on Rinne?

It can occur with normal hearing or sensorineural loss. Interpret alongside the other findings.

Why review masking?

The opposite ear can detect the signal and distort side-specific thresholds.

Ear Wax Topical Delivery and Vestibular History

Practical 04 / Skills laboratory simulation

Aim

Assess when wax needs management, practise an approved model demonstration and distinguish dizziness histories.

Principle

Wax management depends on symptoms, visual access, membrane integrity and contra-indications. Dizziness descriptors and time course help distinguish vestibular and other causes.

Materials and Requirements

- Ear trainer with mock wax
- Topical device trainer and product instructions
- Fictional dizziness card

Procedure

1. Check the indication, symptoms and previous ear surgery or perforation history in the simulation.
2. Check discomfort, discharge, sudden hearing change, previous surgery and whether the membrane is known to be intact. Ask the supervisor to review contraindications before a model removal choice.
3. Review the instructor's authorised removal demonstration on the model and identify stops, contraindications and referral needs.

Continue with step 4 on the next page.

Procedure Continued

Ear Wax Topical Delivery and Vestibular History

4. Inspect the model's canal and membrane view, select the correct authorised demonstration and verify role and equipment checks. State which pain, dizziness or limited visibility would stop the attempt.
5. After the trainer sequence inspect and record remaining wax, canal condition and membrane visibility. If unresolved, give the specific reason for referral or repeat review.
6. Demonstrate simulated topical use with the exact supplied product instructions and verify the role-play patient's understanding.
7. Verify the mock product, ear and dose with the case record. Show positioning and device use according to the product card and avoid contact between the dropper tip and ear.
8. For a dizziness case record time course, triggers, hearing symptoms and neurologic warning signs and decide which assessment should follow.
9. Describe a dizziness episode by onset, duration and trigger, and record new hearing or neurological signs. Recheck the person's understanding of safe follow-up or urgent assessment.

Precautions

- Use the model for removal practice. Avoid blind instrumentation or irrigation when contraindicated.
- Escalate acute dizziness with new neurologic signs promptly.

Observations and Interpretation

Ear Wax Topical Delivery and Vestibular History

Observations and Record

Item	What to record	What it tells you
Wax assessment	Symptoms, membrane status and contraindications	Determines safe route of care
Model skill	Authorised method and stop checks	Recognises when referral is needed
Dizziness history	Duration, triggers and associated signs	Guides urgency and assessment choice

Worked Example

A fictional patient with a history of perforation asks for irrigation. Flag the risk and seek ENT review rather than proceeding with an unverified method.

Result and Interpretation

Document the model demonstration and the appropriate clinical referral or review for each teaching case.

Viva Questions and Answers

When is wax impaction clinically important?

When it causes symptoms or prevents a needed examination.

Why ask about past tympanic membrane perforation?

It can affect the safety of proposed removal methods.

ENT Emergencies Airway Epistaxis and Foreign Body

Practical 05 / Skills laboratory simulation

Aim

Recognise an ENT emergency and demonstrate escalation and safe initial priorities on a trainer.

Principle

Airway compromise and severe bleeding take priority over complete local examination. Age, site, object and clinical state determine the specialist response.

Materials and Requirements

- ENT emergency manikin and inert model equipment
- Case cards for stridor, epistaxis and foreign body
- Emergency activation checklist

Procedure

1. Check immediate airway, breathing and circulation risks and summon the supervised emergency and ENT teams.
2. State scene safety, activate the appropriate emergency response and identify breathing difficulty, stridor, inability to speak or other immediate threats. Apply the instructor’s emergency algorithm to the trainer.
3. For simulated nosebleed record side, severity, medicines and haemodynamic observations and demonstrate the approved basic first-aid response.

Continue with step 4 on the next page.

Procedure Continued

ENT Emergencies Airway Epistaxis and Foreign Body

4. If the simulated patient is stable with a nosebleed, sit them leaning forward and demonstrate continuous pressure to the soft part of the nose as taught. Time it and reassess bleeding and tolerance.
5. Review anticoagulants, trauma and symptoms of blood loss in the case. Escalate ongoing heavy bleeding or instability and identify the team that would perform further treatment.
6. Identify urgent hazards in the case pack including stridor, possible airway foreign body and button battery. Avoid blind attempts to retrieve an object.
7. Match the model object and location to the risk, including airway obstruction or a button battery. Avoid delay and give the supervisor the suspected item, site and time.
8. Observe the instructor's model demonstration of advanced interventions and give a timed handover with response to initial measures.
9. Identify the advanced equipment or intervention being demonstrated by faculty. Record time to escalation, findings, basic actions, response and which interventions remain the specialist team's responsibility.

Precautions

• Avoid blind nasal, oral or ear instrumentation.

• Use the instructor's manikin checklist for invasive procedures.

Observations and Interpretation

ENT Emergencies Airway Epistaxis and Foreign Body

Observations and Record

Item	What to record	What it tells you
Airway	Stridor, effort, voice and oxygenation	Determines urgency
Bleeding or foreign body	Site, history and response	Identifies specialist need
Handover	Time, precautions and immediate concern	Supports coordinated response

Worked Example

A fictional child has noisy breathing and drooling after an acute onset. Call for immediate airway assessment, minimise agitation and follow the local emergency pathway.

Result and Interpretation

Demonstrate early recognition and escalation. Advanced packing, airway and retrieval procedures stay within trained simulation or authorised care.

Viva Questions and Answers

Why prioritise airway over detailed local examination?

Obstruction can worsen rapidly and is immediately dangerous.

What should follow a concerning object history?

Urgent evaluation through the appropriate specialist pathway.

ENT Instruments Endoscopy Findings and Consent

Practical 06 / Spotter and viva

Aim

Identify common ENT instruments and interpret observed otologic, nasal and laryngeal teaching views.

Principle

An instrument is recognised by form and intended task. Endoscopy and microscopy give focused views which are interpreted with orientation, indication and the visibility limits.

Materials and Requirements

- Inert instruments or labelled photographs
- Teaching otomicroscopy, nasal endoscopy and laryngoscopy views
- Fictional consent brief

Procedure

1. Identify the item, field of use and one reason it is selected. State how it is handled safely in a model exercise.
2. Arrange the provided items by ear, nose, throat or airway use. Identify working end, light source or optical path and check the supplied handling and cleaning record.
3. Orient and describe a supplied image by visible landmarks and relevant abnormality. Record any obscured region.

Continue with step 4 on the next page.

Procedure Continued

ENT Instruments Endoscopy Findings and Consent

4. For each teaching image establish side, viewing route and field. Point to a normal landmark before describing lesion site, shape, surface and what the view leaves uncertain.
5. Compare a relevant investigation for otologic, sinonasal and airway or voice complaints and describe its clinical question.
6. Match the clinical question to an appropriate test such as audiometry, nasal examination or laryngeal visualisation. Briefly explain what the result would change in the plan.
7. Check contraindication or escalation prompts in the case materials and identify which parts require the specialist's equipment and competence.
8. Role-play explanation of a proposed specialist procedure with alternatives, key risks and a teach-back question.
9. Explain the proposed procedure, comfort measures, key risks and other options to the actor. Check consent, pause or stop choices and teach-back and document the decision.

Precautions

- Avoid operating a live endoscope outside approved training.
- Use anonymised teaching views and avoid definitive diagnosis from one frame.

Observations and Interpretation

ENT Instruments Endoscopy Findings and Consent

Observations and Record

Item	What to record	What it tells you
Instrument	Name, region and purpose	Connects equipment with clinical task
Image	Orientation, landmarks and finding	Supports a reproducible description
Consent	Purpose, options, questions and choice	Documents a communication skill

Worked Example

A recorded flexible laryngeal view shows asymmetry of vocal fold motion. Describe the movement, side and limits of observation and refer to the specialist report.

Result and Interpretation

Present an instrument spotter, interpreted image and consent discussion. The procedures are taught by observation or model demonstration.

Viva Questions and Answers

Why state the intended use of an instrument?

Different tools can look similar but serve distinct functions.

What should a consent dialogue include?

Purpose, meaningful risks and alternatives, questions and voluntary choice.

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