I. Nose/Sinus

- Acute/Chronic Sinusitis
- Allergic Rhinitis
- Epistaxis
- Foreign Body
- Nasal Polyps

Acute Sinusitis

- **Etiology**
  - SWELLING of the nasal mucous MEMBRANE (i.e. viral/allergic rhinitis)
  - IMPAIRED mucociliary CLEARANCE
  - OBSTRUCTION of osteomeatal complex
  - ACCUMULATION of mucus
  - Secondary bacterial INFECTION
### Acute Sinusitis

#### Pathogens
- **USUAL otitis media suspects:**
  - S. pneumoniae
  - H. influenzae
  - S. aureus & M. catarrhalis (less common)

#### Clinical Findings
- Symptoms > 1 WEEK (but < 4 weeks)
  - Examples:
    - Facial CONGESTION / fullness
    - Nasal DRAINAGE / discharge
    - Postnasal DRIP
    - Nasal OBSTRUCTION / blockage
    - FEVER
    - ↓ or absent sense of SMELL
  - UNILATERAL PAIN (i.e. toothache / over maxillary sinus)
  - CHANGE in SECRETIONS (watery / mucoid >>> purulent green / yellow)

#### MAXILLARY Sinus
- MOST commonly affected – largest/ostia superior
- Pain/pressure over CHEEK

#### Frontal Sinusitis
- Pain / tenderness of FOREHEAD
Acute Sinusitis

**Imaging Studies**
- CLINICAL diagnosis...usually
- Routine X-RAYS: more sensitive, but NOT recommended
  - Can be helpful if questionable
  - Hallmarks:
    - SOFT tissue DENSITY
    - WITHOUT bone DESTRUCTION
    - +/- AIR / FLUID levels
  - Not COST effective

**CT**
- MORE sensitive (to inflammation / bone destruction)...but NOT specific
- May be helpful for endoscopic surgery (recurrent / chronic sinusitis)
- May help for confirmation, rule out, or monitoring

**Sinusitis → *CLINICAL diagnosis***

**Treatment**
- NSAIDs: pain relief
- DECONGESTANTS (oral and/or nasal) for symptomatic relief
  * (i.e. PO pseudoephedrine, nasal oxymetazoline or xylometazoline)
Acute Sinusitis

- **Antibiotics**
  - **FIRST-line (7-10 days)**
    - Amoxicillin
    - TMP-SMZ (PCN allergic)
    - Doxycycline (PCN allergic)
  - **AFTER recent ABX use**
    - Levofloxacin
    - Amoxicillin-clavulanate
- **SECOND-line (10 days) — if no improvement**
  - Amoxicillin-clavulanate (after 3 days of 1st line)
  - Moxifloxacin (after 3 days of 1st line)

Chronic Sinusitis

- **Symptoms (> 3 MONTHS)**
- **DIFFERENT pathogens**
  - Including gram negatives, S. aureus, anaerobes
  - LONGER antibiotic course [weeks]
    - Recommended: amoxicillin-clavulanate, cefuroxime, gatifloxacin, moxifloxacin, or clindamycin
    - Culture-directed therapy recommended
- **Surgery: IF REFRACTORY to medical treatment**

Allergic Rhinitis

- **“Hay Fever”**
  - **SYMPTOMS like viral rhinitis**
    - BUT usually PERSISTENT/SEASONALY related

- **Etiology**
  - **ALLERGENS**
    - pollens (spring)
    - grasses (summer)
    - ragweed/mold (fall)
    - dust/miles/pet dander (year-round)
Allergic Rhinitis

• Clinical Findings
  – NASAL symptoms (runny nose)
  – EYE irritation (i.e. pruritus, erythema, tearing)
  – PALE or VIOLACEOUS mucosa

• Treatment
  – OTC ANTIHISTAMINES
    • Brompheniramine, chlorpheniramine, clemastine
    • Loratadine, cetirizine
  – “NEWER” antihistamines
    • Fexofenadine (non-sedating)
    • Desloratadine (minimally sedating)

  – Antihistamine Nasal SPRAYS
    • i.e. levocabastine, azelastine (Astelin)
  – “Tolerance”
Allergic Rhinitis

• * Intransal CORTICOSTEROIDS *
  – May take 2 or more WEEKS to work
  – SHRINK nasal polyps
  – Examples
    • beclomethasone, flunisolide
    • mometasone furoate, fluticasone propionate

Allergic Rhinitis

• Others (examples)
  – LEUKOTRIENE receptor antagonists (i.e. montelukast)
  – Intransal IPRATROPIUM bromide
  – Nasal SALINE irrigation

Epistaxis

• Etiology (predisposing factors)
  – Nasal TRAUMA
  – RHINITIS
  – ↓ HUMIDITY
  – HTN, nasal cocaine use, alcohol
Epistaxis

• Treatment
  – Anterior
    • Usually * DIRECT PRESSURE to area *
  – TOPICAL nasal DECONGESTANTS (i.e. phenylephrine)
    • Cocaine – anesthetic / vasoconstrictor
      – Substitute topical decongestant (i.e. oxymetazoline) and a topical anesthetic (i.e. tetracaine)

Epistaxis

• Treatment, continued
  – Cautery
  – Anterior PACKING (i.e. iodoform packing, foam, nasal balloons)
  – Posterior packing – more difficult

Foreign Body

• Peds vs. adults
• Asymptomatic (WITNESSED)
• Symptomatic
  – UNILATERAL nasal DISCHARGE
  – BAD odor
  – Sneezing, bleeding, pain
• Treatment (REMOVAL)
  – Depending on COMPOSITION, POSITION, PRACTITIONER COMFORT, patient COMPLIANCE
    → ENT
<table>
<thead>
<tr>
<th>Nasal Polyps</th>
<th>Nasal Polyps</th>
<th>II. Mouth/Throat</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Etiology</strong></td>
<td><strong>Treatment</strong></td>
<td><strong>Acute Pharyngitis / Tonsillitis</strong></td>
</tr>
</tbody>
</table>
| – ALLERGIC? | – TOPICAL nasal CORTICOSTEROIDS  
| – SYSTEMIC disease? | • 1-3 MONTHS | • Aphthous Ulcers |
| **Clinical Findings** | – ORAL steroids (short course)  
| – PALE mucosal MASS | • Prednisone | • Dental Abscess |
| – Nasal OBSTRUCTION | – Surgical REMOVAL  
| – ↓ SMELL | • With failed medical management/large polyps | • Epiglottitis |
| | | • Laryngitis |
| | | • Neoplasm (Laryngeal SCC) |
II. Mouth/Throat

• Oral Candidiasis
• Oral Herpes Simplex
• Oral Leukoplakia
• Peritonsillar abscess
• Parotitis
• Sialadenitis

Acute Pharyngitis / Tonsillitis

• General Points
  – Very COMMON
  – * GABHS * - Complications
  – ANTIBIOTIC resistance / cost

• CLINICAL Findings, continued
  – ODYNOPHAGIA
  – “Scarlatiniform” RASH
    • Fine erythematous papular rash – SANDPAPER
    – Possible elevated WBC/left shift

• NOT suggestive of GABHS
  – Hoarseness, cough, coryza
  – Rhinorrhea, no exudate → viral
Acute Pharyngitis / Tonsillitis

• Possible Differential Diagnosis Item
  – MONOncleosis
  • Prominent ADENOPATHY
  • Tonsillar EXUDATE (white-purple)
  • YOUNG ADULT
  • ORGANOMEGALY (liver/spleen)

• Treatment (GABHS)
  – IM penicillin x 1 - OUCH
  – ORAL ANTIBIOTICS
    • Penicillin V
    • cefuroxime axetil
    • Erythromycin/azithromycin (PCN allergy)

• Caveats
  – Treatment failures: use amoxicillin /clavulanate or same drug again
  – Appropriate antibiotic treatment to avoid COMPLICATIONS
    – (i.e. scarlet fever, glomerulonephritis, rheumatic myocarditis, local abscess formation)
Acute Pharyngitis / Tonsillitis

- Treatment, continued
  - Analgesics
  - Anti-inflammatory agents
    - (i.e. aspirin, acetaminophen)
  - Salt water gargles
  - Anesthetic gargles / lozenges
    - (i.e. viscous lidocaine)

Aphthous Ulcers

- “Canker sore” or ulcerative stomatitis
- Very COMMON
- Etiology
  - Human HERPESVIRUS 6?

Aphthous Ulcers

- Clinical Findings
  - NONKERATINIZED mucosa
  - Single OR multiple
  - PAINFUL
  - Round ULCERATION
    - Yellow-gray center surrounded with red halo
Aphthous Ulcers

- Lab / Diagnostic Studies
  - CLINICAL diagnosis
  - Unclear → biopsy

- Treatment
  - Topical / oral corticosteroids – symptomatic help

Dental Abscess

- Definition

- Etiology

- Clinical Findings
  - * PAIN *
    - Tooth is painful to move or bite with.
  - Localized SWELLING

Dental Abscess

- Treatment
  - DENTAL surgical intervention
    - I&D
  - Antibiotics
    - IV (i.e. penicillin, clindamycin, ampicillin-sulbactam)

- Complications
Epiglottitis

• “Supraglottitis”

• Etiology
  – Viral or bacterial

• Clinical Findings
  – Adults
    • Rapidly developing sore throat
    • Odynophagia out of proportion to exam

Epiglottitis

• Other Signs /Symptoms
  – 1-2 days worsening dysphagia, odynophagia, dyspnea
  – Fever, tachycardia, cervical adenopathy
  – Drooling, STRIDOR
  – Patient POSITIONING
  – Secretions
  – Minimal or no cough

Epiglottitis

• Lab/Diagnostic Studies
  – Lateral NECK FILM
    • Enlarged epiglottis
      – “THUMBPRINT sign”
  – LARYNGOSCOPY
    • Swollen, red epiglottis
Epiglottitis

- **Treatment**
  - Hospitalization
  - IV antibiotics (examples)
    - Ceftizoxime, cefuroxime
  - Corticosteroids (i.e. dexamethasone)
  - Monitor airway
  - Intubation (< 10% adults)
    - For severe dyspnea, rapid course

Laryngitis

- **General Points**
  - HOARSENESS
  - Following URI ~ 1 week
  - Avoid singing, shouting

- **Etiology**
  - Usually viral
  - May get bacterial infection

- **Clinical Findings**
  - *HOARSENESS*
  - Difficulty talking
  - Cough, odynophagia

- **Treatment (CONSERVATIVE)**
  - Rest, fluids
  - Antibiotics, if necessary
    - May reduce hoarseness and cough
  - Corticosteroids (i.e. performers)
**Laryngeal SCC**

- HOARSENESS (NEW; > 2 weeks) & **SMOKER**
- OTHER symptoms
  - PAIN, BLOOD, problems SWALLOWING
  - AIRWAY issues
- **Dx:** LARYNGOSCOPY (BX)
  - CT/MRI

- Treatment (early): RADIATION, surgery
- Advanced – chemotherapy/radiation, surgery

---

**Oral Candidiasis**

- **“Thrush”**
- PAINFUL, CREAMY-WHITE over RED
- Can be RUBBED-OFF
- Stem: DENTURES, SICKLY, POOR ORAL, DM, ↓ IMMUNITY, ABX

- **CLINICAL dx**
- **HIV?**

---

**Oral Candidiasis**

- Treatment
  - FLUCONAZOLE (Diflucan®)
  - KETOCONAZOLE (Nizoral®)
  - Clotrimazole troches (Mycelex®)
  - Nystatin (Mycostatin®)
Oral Herpes Simplex

• “Cold” or “Fever sores”

• Etiology
  - HSV-1
    + 85% of adults
    + Acquired in childhood
  - HSV-2
    + 25% of population
    + Acquired by sexual contact
  - Oral (HSV-1?) vs. genital (HSV-2?)

• General Points
  - RECURRENT, self-limited episodes
  - After minor infections, trauma, stress, or sun exposure

• CLINICAL Findings
  - Burning, stinging

Oral Herpes Simplex

• Treatment
  - Immunocompetent
    □ None
  - Systemic Agents (for 7-10 days)
    □ acyclovir, valacyclovir, famciclovir
  - Most recurrent – mild (no treatment)

Topical antivirals (generally not helpful)
Use only for approved indications (i.e. 5% acyclovir ointment)
Oral Leukoplakia

- **Etiology**
  - Usually CHRONIC IRRITATION
  - Some either dysplasia or early squamous cell CA
  - ALCOHOL / TOBACCO major risk factors for SCC

- **CLINICAL Findings**
  - WHITE lesion
  - CANNOT be scraped off (unlike oral candidiasis)
  - Usually small, but can reach several cm

Oral Leukoplakia

- **Lab/Diagnostic Studies**
  - Any erythroplakia or enlarging = BIOPSY/cytologic exam (scraping)

- **Treatment**
  - Referral (i.e. ENT)
  - Benign/minimally dysplastic
    - Close follow-up OR elective excision
  - Premalignant/moderate dysplasia
    - Removal

  - Antioxidants/retinoids helpful?
    - Chemoprevention/regression
    - No approved therapies for reversing/stabilizing

Peritonsillar Abscess

- **General Points**
  - Common deep-space infection of head and neck
  - Infection penetrates tonsillar capsule

- **RISK factors**
  - Chronic tonsillitis, multiple oral antibiotic trials, previous episode

- **Etiology**
  - Cultures
    - usually mixed (aerobic/anaerobic flora)
Peritonsillar Abscess

- **Clinical Findings**
  - Severe sore throat and odynophagia
  - Trismus
  - Abnormal muffled voice
  - Inflammation of tonsil and nearby tissues
  - Medial deviation of soft palate

- **Lab/Diagnostic Studies**
  - (CT/ultrasound)
  - Needle aspiration is fine

- **Treatment (some controversy)**
  - Antibiotics
  - Needle aspiration
  - I&D
  - Tonsillectomy

- **Treatment, continued (all are effective)**
  - Some I&D, then continue with IV antibiotics
  - Others aspirate only, monitor as outpatient
  - Can also consider immediate tonsillectomy
    - To drain abscess / prevent recurrence
**Parotitis**

- **Definition**
  - Inflammation of the **PAROTID** gland

- **Differential Diagnosis (VARIED)**
  - Parotid duct calculi, tumors, cysts, bacterial infection
  - Systemic disease (i.e. sarcoidosis, cirrhosis)
  - Mumps
  - Drug reaction, viruses

**Parotitis**

- **Mumps**
  - **Etiology**
    - Paramyxovirus
    - Usually pediatric cases (most often in spring)
    - Spread by respiratory droplets

  - **Clinical Findings**
    - Painful swelling of salivary glands (usually parotid)
    - Can affect other tissues (i.e. testes, pancreas)

**Sialadenitis**

- **Definition**
  - Inflammation of a **SALIVARY** gland
  - Varied causes

- **Acute BACTERIAL Sialadenitis**
  - **Etiology**
    - With dehydration or chronic illness (i.e. Sjogren's syndrome)
    - Ductal OBSTRUCTION (usually by mucus plug) then salivary STASIS and secondary INFECTION
Sialadenitis

- Acute Bacterial Sialadenitis, continued
  - SWELLING
  - WORSE with MEALS
  - PAIN and REDNESS of DUCT opening (PUS)

Sialadenitis

- Treatment
  - ANTIBIOTICS
    - IV (i.e. nafcillin) to oral with improvement

Sialadenitis

- Salivary gland ENLARGEMENT
  - OTHER causes
    - Systemic: i.e. Sjogren's disease, sarcoidosis
    - Metabolic: i.e. alcoholism, DM, vitamin deficiencies
    - Drugs: i.e. iodine, thioureas
    - Tumor: 80% of salivary gland tumors in parotid
      - 80% benign in adults
III. Ear Disorders

- Acoustic Neuroma
- Barotrauma
- Cerumen Impaction
- Cholesteatoma
- Hearing Impairment
- Mastoiditis

III. Ear Disorders

- Meniere’s disease
- Labyrinthitis
- Tympanic membrane perforation
- Vertigo
- (Otitis media/externa)

Acoustic Neuroma

- UNILATERAL (usually)
- BENIGN
- UNILATERAL hearing LOSS
- ↓ speech DISCRIMINATION
- CONTINUOUS dysequilibrium

- Dx
- MRI
- Tx
- DEPENDS
  - Observation
  - Microsurgery
  - Radiotherapy
Barotrauma

• Definition
  – Injury caused by changes in atmospheric pressure between a potentially closed space and the surrounding area

• Etiology
  – Eustachian tube dysfunction
    • (i.e., congenital narrowness or acquired mucosal edema)

• Clinical Findings
  – Ear pain / hearing loss

Barotrauma

• Treatment
  – Decongestants
  – Autoinflation
  – Myringotomy (immediate relief)
    • Making a small eardrum perforation
    • For severe otalgia and hearing loss

• Patient Education Points
  – Swallow, yawn, autoinflate during decent
  – Systemic decongestants
    • (i.e., pseudoephedrine)
    • Take several hours before arrival
  – Topical decongestants
    • (i.e., phenylephrine nasal spray)
    • 1 hour before arrival

— Barotrauma —

— Barotrauma —

— Barotrauma —
Barotrauma

- Diving
  - More barometric stress vs. flying
  - Avoid diving with URI or nasal allergy episodes
  - Tympanic membrane perforation
    - **ABSOLUTE contraindication to diving**

Cerumen Impaction

- **Cerumen: "EARWAX"**
  - Serves a protective function
    - Acidic pH inhibits bacteria

- **Etiology**
  - Usually **SELF-induced**
    - (i.e. cotton swab inside ear canal)
  - More common in **ELDERLY**
    - Age-related changes
      - More coarse, large hairs in ear
      - Cerumen gland atrophy leads to drier wax

- **CLINICAL Findings**
  - Sudden or gradual HEARING LOSS (uni- or bilateral)
  - Otoscope: OBSTRUCTION of canal by cerumen

- **Treatment**
  - REMOVAL
    - Detergent ear drops (i.e. 3% hydrogen peroxide)
    - Mechanical (i.e. curette)
    - Suction or irrigation (i.e. 50/50 mix of peroxide and WARM water)
### Cholesteatoma

- **Etiology:** EUSTACHIAN tube DYSFUNCTION
  - ( - ) middle ear PRESSURE
  - TM deformation → SAC → FILLS up → INFECTION
  - EAT through BONE
- **Exam:** upper RETRACTION / PERFORATION with KERATIN / GRANULATION tissue
- **Tx:** SURGERY

### Hearing Impairment

- **CONDUCTIVE**
  - Problem of external or middle ear (affects sound traveling to inner ear)
  - **Causes**
    - Obstruction: (cerumen impaction)
    - Mass loading: (middle ear infection)
    - Stiffness: (otosclerosis)
    - Discontinuity (ossicular disruption)
  - In adults, usually from cerumen impaction or URI (auditory tube dysfunction)
  - Persistent conductive loss (i.e. from chronic ear infection, trauma or otosclerosis)
  - Generally correctable with medical and/or surgical tx

- **SENSORY**
  - Cochlear deterioration
    - Hair cell loss from the organ of Corti
  - Gradual, progressive mostly high frequency loss with AGING
  - **OTHER common CAUSES**
    - Noise
    - Head trauma
    - Systemic disease (i.e. DM)
  - Not correctable, but may be prevented/stabilized
  - Exception: sudden hearing loss - corticosteroids

---
Hearing Impairment

• Neural
  – LEAST COMMON cause
  – Lesions of nerve, neural pathway or CNS processing center
    • (i.e. acoustic neuroma, MS, cerebrovascular disease)

• Lab / Diagnostic Studies
  – Physical EXAM
    • To whisper, spoken voice, or shout
  – Tuning forks (512-Hz) – conductive vs. sensorineural
  – AUDIOMETRY
    • Thresholds
      – Normal hearing: 0-20 dB (soft whisper)
      – Mild loss: 20-40 dB (soft spoken voice)
      – Moderate loss: 40-60 dB (normal spoken voice)
      – Severe loss: 60-80 dB (loud spoken voice)
      – Profound loss: 80 dB (shout)
    • Speech discrimination testing
      – Clarity of hearing often lost with sensorineural problems
        • Normal: 90-100% correct

Mastoiditis

• Etiology
  • Usually AFTER acute OTITIS media that was inadequately treated

• Clinical Findings
  • POSTAURICULAR PAIN, erythema
  • FEVER
Mastoiditis

• Treatment
  – Initially IV antibiotics (i.e. ceftriaxone)
  – Myringotomy: for culture / drainage
  – Surgical drainage (mastoidectomy)
    • With medical treatment failure

Vertigo

• Definition
  – SENSATION of MOTION
    • When there is none, or exaggerated sense of motion
  – Symptom of VESTIBULAR disease
  – “Tumbling, falling, ground rolling”

• PERIPHERAL Vestibulopathy
  – Usually sudden onset
  – Often with nausea / vomiting
  – Tinnitus & hearing loss
  – Horizontal nystagmus

• CENTRAL Origin
  – More gradual progression
  – Vertical nystagmus
  – MRI helpful
Vertigo

Clinical Findings
- Assess Romberg, gait, nystagmus

Nylen-Barany (Dix-Hallpike) maneuvers

Lab/Diagnostic Studies
- (i.e. audiologic testing, CT, MRI)
- Indicated with persistent vertigo / suspected CNS disease

Symptomatic Treatment
- (i.e. meclizine, scopolamine)

Varied Differential
- (i.e. diplopia, cerebral lesions, seizures, systemic diseases, drugs, alcohol)

Meniere's Disease

Endolymphatic hydrops

Clinical Findings
- Repeated episodes (usually about 20 minutes to several hours)

Hearing Loss
- Fluctuating, worse in lower ranges, progressive
- Usually UNILATERAL

Tinnitus
- Low pitched, "blowing"

Aural Pressure

Etiology
- Increased volume of endolymph (fluid)
- Exact pathogenesis unknown

Clinical Findings
- Acute episode
- Horizontal and / or rotary nystagmus

Hearing Loss
- May be mild

Auditory Low pitch, rough, "booming"

Meniere's Disease
Meniere’s Disease

• Treatment
  – Goal: lower endolymphatic pressure
    • Low salt diet (< 2 grams / day)
    • Diuretics (i.e. HCTZ, acetazolamide)
  – Meclizine or scopolamine for acute episodes
  – Surgery: if persistent, disabling, drug-resistant

• General Points
  – Vertigo resolves as hearing loss worsens
  – Majority (middle-aged) stabilize

Labyrinthitis

• VERTIGO
  – ACUTE onset, CONTINUOUS, usually severe
  – Several DAYS to a WEEK
  – With hearing loss, tinnitus
  – Recovery period (several weeks)
    • Rapid head movements → vertigo

• Etiology
  – ??? - Often AFTER URI

• Treatment
  – Meclizine (short-term), antibiotics (if febrile/bacterial infection symptoms), bed rest

Tymppanic Membrane Perforation

• Etiology
  – TRAUMA
    • direct / penetrating
  – PRESSURE CHANGES
    • water / air (barotrauma, blast injuries)
  – CHRONIC OTITIS media
  – IATROGENIC
    • (i.e. foreign body removal)
Tympanic Membrane Perforation

- Clinical Findings
  - SUDDEN ear pain, vertigo, tinnitus, hearing change (AFTER SPECIFIC event)
  - Otoscopy: slit-shaped TEAR or larger irregular DEFECT
  - Marginal vs. central
    • First is less common, extends more to TM edge

- Treatment
  - Antibiotics
    • NOT helpful UNLESS caused by OTITIS media
  - NO topical STEROIDS (impede closure)
  - Refer to ENT
    • For follow-up / possible repair
  - Most heal spontaneously (80%)

References

- Bates’ Guide to Physical Examination and History Taking, 10th edition
- Cecil Textbook of Medicine
- Current Medicine (2013)
A patient presents with nasal congestion and yellowish drainage x 10 days. On exam, he is afebrile but is tender over the cheek. Which of the following is the most likely diagnosis?

1. acute sinusitis
2. allergic rhinitis
3. chronic sinusitis
4. viral rhinitis

1. acute sinusitis
2. allergic rhinitis
3. chronic sinusitis
4. viral rhinitis

An otherwise healthy patient presents with nasal congestion and yellowish drainage x 10 days. On exam, he is afebrile but is tender over the cheek. Which of the following diagnostic tests is indicated at this time?

1. CT
2. MRI
3. X-ray
4. none of the above
An otherwise healthy patient presents with nasal congestion and yellowish drainage x 10 days. On exam, he is afebrile but is tender over the cheek. Which of the following diagnostic tests is indicated at this time?

1. CT
2. MRI
3. X-ray
4. none of the above

A patient presents with nasal congestion and yellowish drainage x 10 days. On exam, he is afebrile but is tender over the cheek. He is allergic to penicillin. Which of the following is the best initial treatment?

1. amoxicillin-clavulanate
2. levofloxacin
3. moxifloxacin
4. trimethoprim-sulfamethoxazole

A patient presents with nasal congestion and yellowish drainage x 10 days. On exam, he is afebrile but is tender over the cheek. He is allergic to penicillin. Which of the following is the best initial treatment?

1. amoxicillin-clavulanate
2. levofloxacin
3. moxifloxacin
4. trimethoprim-sulfamethoxazole

1. amoxicillin-clavulanate
2. levofloxacin
3. moxifloxacin
4. trimethoprim-sulfamethoxazole
A 42-year-old truck driver presents complaining of runny nose and itchy/watery eyes. On exam, his nasal mucosa appear pale. For the most likely diagnosis, which of the following is the best treatment?

1. OTC antihistamine
2. Intranasal corticosteroid
3. Leukotriene antagonist
4. Intranasal cromolyn

A 42-year-old female presents with fever, sore throat, and painful swallowing, but denies any other cold/URI symptoms. On exam, she has an erythematous pharynx with exudate, and tender anterior cervical adenopathy. Which of the following is the most likely diagnosis?

1. Diphtheria
2. Mononucleosis
3. Peritonsillar abscess
4. Strep pharyngitis
A 11-year-old female presents with fever, sore throat, and painful swallowing, but denies any other cold/URI symptoms. On exam, she has an erythematous pharynx with exudate, and tender anterior cervical adenopathy. Which of the following is the most likely diagnosis?

1. diphtheria
2. mononucleosis
3. peritonsillar abscess
4. strep pharyngitis

1. elective excision
2. systemic acyclovir
3. topical antiviral
4. none of the above
A patient presents complaining of sudden ear pain and change in hearing after using a cotton swab in the ear canal. For the most likely diagnosis, which of the following is correct?

1. Topical antibiotics are indicated.
2. Most cases resolve spontaneously.
3. Topical steroids should be used.
4. none of the above

Topical antibiotics are indicated.

Most cases resolve spontaneously.

Topical steroids should be used.

None of the above

Thank You and Good Luck!