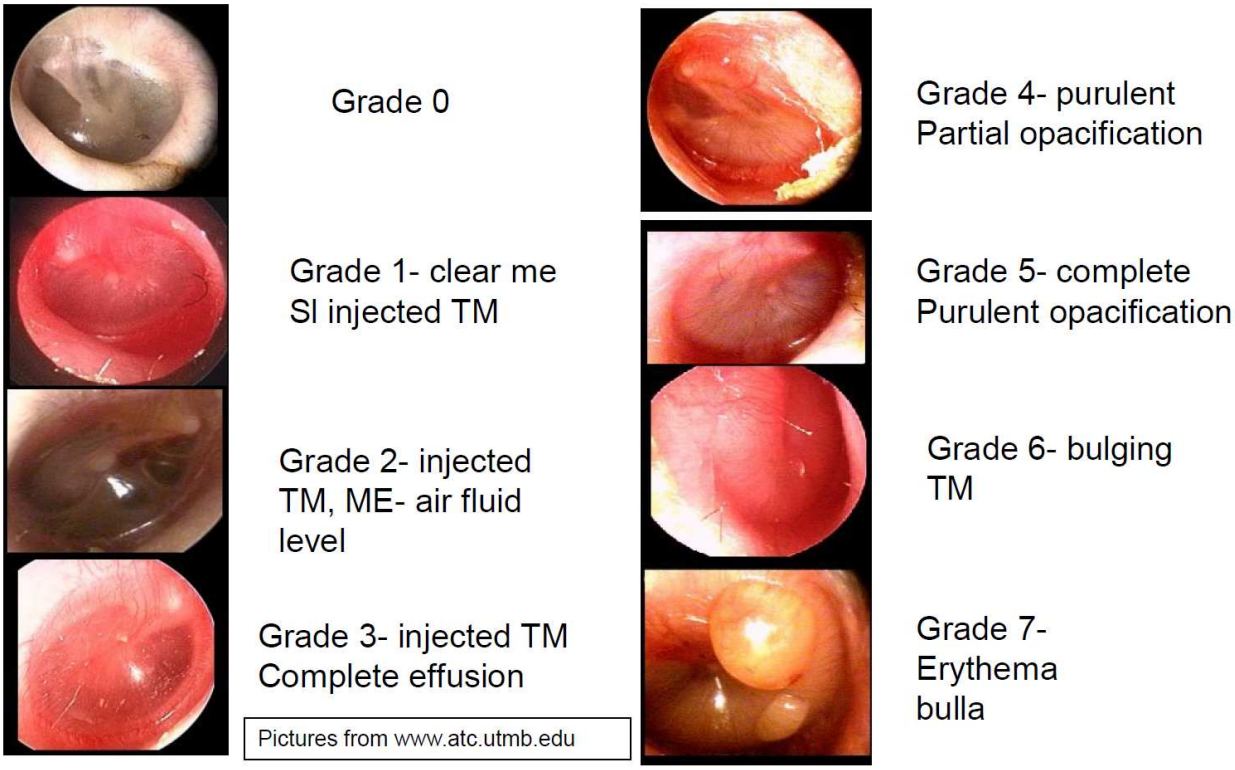
Definitions

Myringitis

- Red (inflammed) eardrum
- Positive predictive value (PPV) for AOM is as low as 7%

Acute otitis media (AOM)

- Middle ear infection – 25% viral, else S.pneumoniae, H influenza, Moraxella catarrhalis
  - Inflammation – acute pain, fever, myringitis
  - Purulent effusion ± discharge (with perforation the pain↓↓)
  - Bulging drum with loss of mobility (85-99% PPV)



Otitis media with effusion (OME)

- AKA serous otitis media
- Fluid (non-purulent) behind drum, no inflammation
- May last 6-16 wks → glue ear

Chronic supporative otitis media

- Persistent inflammation >6wks
- Perforated eardrum
- Draining exudate

Management

- Poorer outcome factors: young age, child care, dummy use, family history, formula feeding, prev episodes, parental smoking=. BF>3mo protective
- Analgesia
  - Ibuprofen or paracetamol
  - Topical LA (**Auralgin**) or natropathic ear drops may be beneficial at 30mins
- Decongestants & antihistamines not helpful in AOM
- Oral Antibiotics
  - 66% resolve within 24hrs whether given ABx or not.
  - 80% resolve without ABx in 2-7 days.

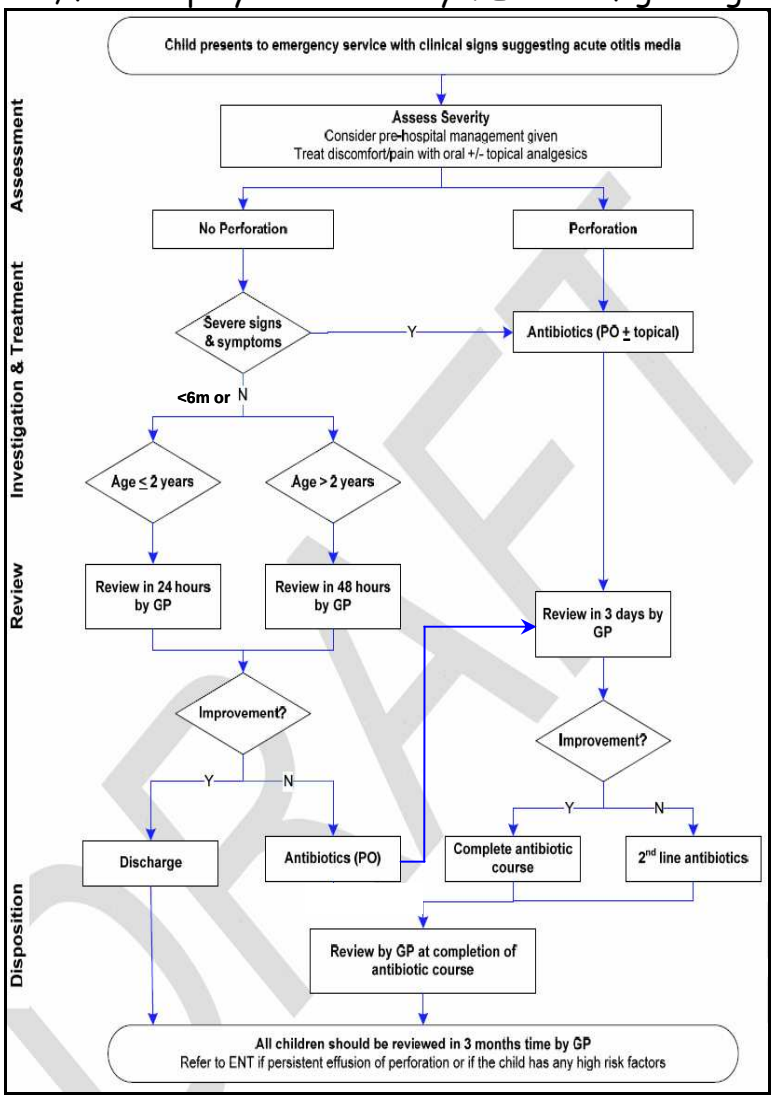
- If treated with ABx only 7% children have no pain after 48hrs.
- No benefit over placebo in hearing changes or recurrence rate
- No conclusive proof of decrease in mastoiditis with ABx
- Greatest benefit from ABx if age<2 or high fever & vomiting
- Side effects from ABx in 1:6 children treated (e.g. nausea, diarrhoea, rash)
- 1st line: **amoxicillin** 15mg/kg tds PO x 5d. if penicillin allergic: macrolide e.g. **azithromycin** 10mg/kg od PO x 3d. 2nd line: **Augmentin** 22.5mg/kg bd PO after 3d
- 5 days is normally as effective as 10 days.
- No evidence that higher doses more effective
- Prophylactic ABx halve yearly recurrence rate if high risk

- Topical ABx (**ciprofloxacin**) if perforation

Summary of AOM Mx

If realistically likely bacterial AOM:

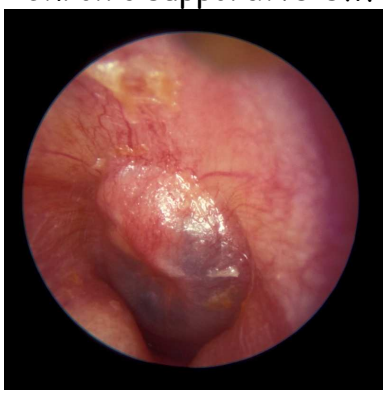
- Red, bulging drum, purulent effusion/discharge, treat by age:
  - <=6mo: Analgesia + Antibiotics
  - >6mo – 2 yrs: Analgesia + Delay ABx 24hrs unless severe
  - >2ys: Analgesia + Delay ABx 48hrs unless severe
  - Have lower threshold for ABx in Indigenous children
  - If ABx given, follow up by GP in 3-5 days. Earlier if getting sicker

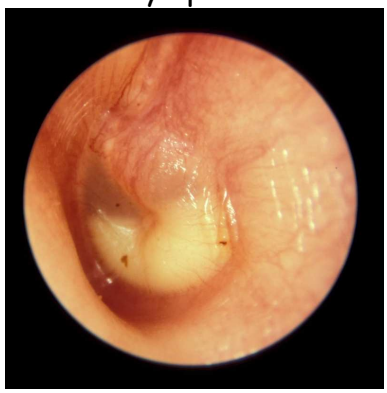


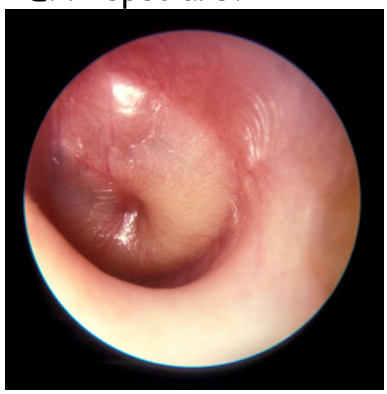
- Notes: Severe Sign/Symptoms = Vomiting + High Fever.
  Only add topical ABx if perforation or in situ grommet.

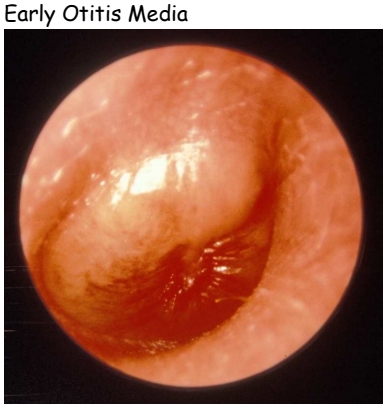
Complications

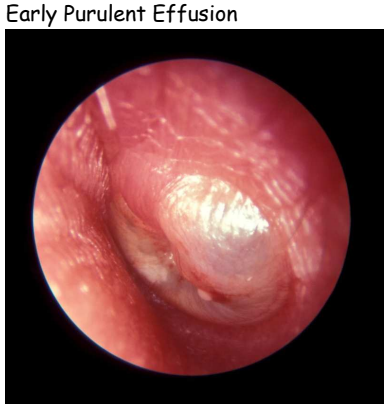
- Effusion post-AOM: 50% at 1mo, 10% at 3 mo, If hearing loss → ENT specialist
- Mastoiditis - Rare <1:2000
- Meningitis
- Facial paralysis
- Intracranial abscess
- Lateral sinus thrombosis
- Recurrence: if >3 episodes in 6mo or 4 in 1 yr → ENT specialist
- Chronic supporatve OM or retracted tympanic membrane: → ENT specialist

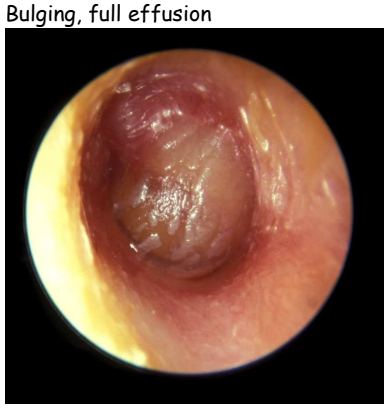

Early Otitis Media

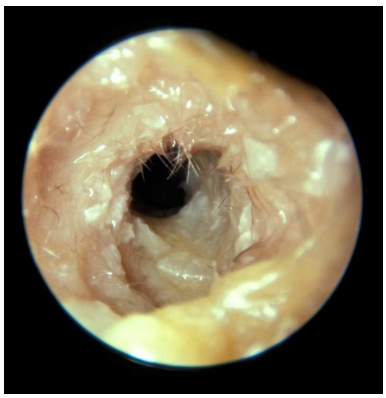

Early Purulent Effusion

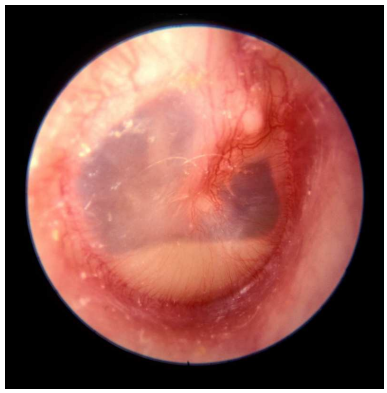

Bulging, full effusion

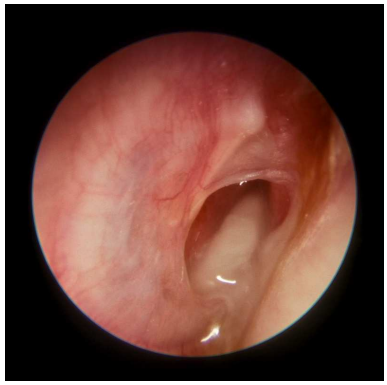

Advanced supporation + haemorrhage

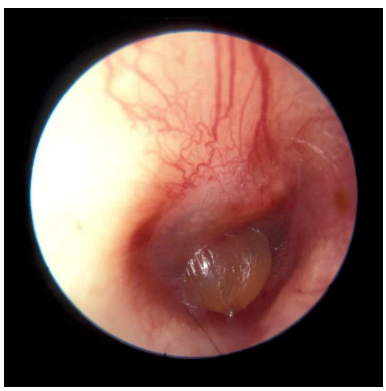

Pre-perforation

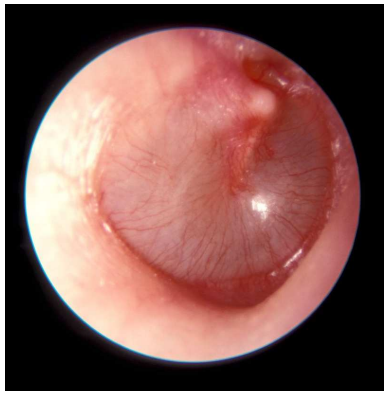

Bulging + early perforation

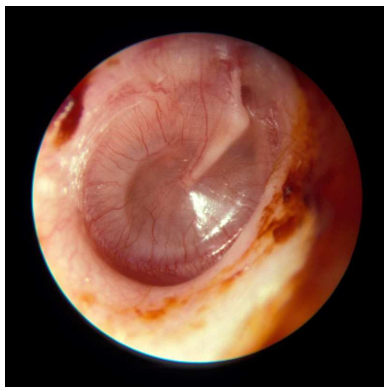

Frank Perforation + Discharge


Residual Effusion post-AOM


Chronic Supporative


Bullous Myringitis


OM with effusion


Glue Ear – drum retraction, opaque fluid