

## Guideline Highlights

### Acute Otitis Media – age 2 mo to 13 years

**Target Population:** Children 2 months to 13 years of age with signs and symptoms of acute otitis media (AOM)

**Exclude:**

- Children with a comorbid condition increasing the risk of severity of AOM, including immunodeficiencies, craniofacial or neurologic abnormalities, or sensory deficits
- Children with PE tubes in place

**Goal:** To help practitioners accurately diagnose AOM and assess parameters for appropriate selection of treatment options which include pain relief, antibiotic therapy and/or observation.

### General Highlights and Recommendations

1. Accurate diagnosis of AOM is important and it is recommended that pneumatic otoscopy be used to enhance accuracy. Diagnosis of AOM requires all of the following:
  - ◆ history of acute onset of signs and symptoms
  - ◆ presence of middle ear effusion (MEE)
  - ◆ signs and symptoms of middle ear inflammation
2. Assess and treat for ear pain. Immediate treatment with a safe and effective analgesic is more important than which agent is used.
3. For children less than 2 years of age, treat AOM with a 10-day course of high dose amoxicillin.
4. For children 2 years of age and older and who are well-appearing, discuss AOM treatment options with the family. These include:
  - ◆ safety-net antibiotic prescription (SNAP), or
  - ◆ 5-day course of high dose amoxicillin

#### **SNAP definition**

- SNAP is a prescription for an appropriate antibiotic, as determined by the practitioner, written to be filled only within 5 days of the office visit.
- Instruct the parent not to fill SNAP unless symptoms worsen at any time or unless symptoms do not improve during a waiting period of 48 - 72 hours.
- Instruct the parent that a well-appearing child diagnosed with AOM may quickly progress to a more severe case, and to call and/or follow-up with practitioner if this occurs.

5. For children 2 years of age and older with severe illness, treat AOM with a 5-day course of high dose amoxicillin.
6. Select 2<sup>nd</sup> line antibiotic therapy when recurrence less than 1 month from previous episode of AOM, if penicillin allergy present, for a child who has been on antibiotics for other reasons, or when there are other reasons to consider an alternative.
7. Other therapies are not recommended, including: prolonged or prophylactic antibiotics, steroids, antihistamines and decongestants.
8. Reexamine child if symptoms worsen at any time or do not improve in 48-72 hours. If AOM is still the appropriate diagnosis, start high dose amoxicillin (if previously observed without antibiotic therapy) or change to a 2<sup>nd</sup>-line antibiotic, as appropriate.
9. Reevaluate child 4-8 weeks after diagnosis to evaluate for resolution or persistence of middle ear fluid.
10. Refer for audiologic evaluation if concerns are raised about hearing, speech or language because of recurrent AOM.
11. Refer for otolaryngological evaluation for recurrent AOM, persistent otorrhea, concerns about mastoiditis or other complications of AOM, perceived need for tympanocentesis and/or myringotomy, abnormal audiologic evaluation.
12. Educate family on natural history of AOM and MEE, observation and follow-up skills, preventable risk factors.