Treatment Options for AOM

This teaching presentation for the ISOM website has been prepared by

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Acknowledgement

- This presentation is aimed for teaching purposes of students, residents and other allied healthcare workers
- Please visit the International Society for Otitis Media website for more resources, www.otitismediasociety.org

American Academy of Pediatrics Recommendations (2004, 2013)

- Evidence-based clinical practice guideline that provides recommendations to clinicians for the management of children from 2 months -12 years of age with uncomplicated AOM.

- Excluded are: anatomic abnormalities such as cleft palate, genetic conditions such as Down syndrome, immunodeficiencies, and the presence of cochlear implants. Also excluded are children with a clinical recurrence of AOM within 30 days or AOM with underlying chronic OME.

Criteria for Initial Antibacterial-Agent Treatment or Observation in Children With AOM

Age	Certain Diagnosis	Uncertain Diagnosis
<6 mo	Antibacterial therapy	Antibacterial therapy
6 mo to 2 y	Antibacterial therapy	Antibacterial therapy if severe illness; observation option* if non-severe illness
>2 y	Antibacterial therapy if severe illness; observation option* if non-severe illness	Observation option*

If the patient fails to respond to the initial management option within 48 to 72 hours, the clinician must reassess the patient to confirm AOM and exclude other causes of illness. If AOM is confirmed in the patient initially managed with observation, the clinician should begin antibacterial therapy. If the patient was initially managed with an antibacterial agent, the clinician should change the antibacterial agent.

≥

Temperature 39°C and/or Severe Otalgia	At Diagnosis for Patients Being Treated Initially With Antibacterial Agents		Clinically Defined Treatment Failure at 48–72 Hours After Initial Management With Observation Option		Clinically Defined Treatment Failure at 48–72 Hours After Initial Management With Antibacterial Agents	
	Recom	Alternative for Penicillin Allergy	Recom	Alternative for Penicillin Allergy	Recom	Alternative for Penicillin Allergy
No	Amoxicillin, 80–90 mg/kg per day	Non–type I: cefdinir, cefuroxime, cefpodoxime; type I: azithromycin, clarithro	Amoxicillin, 80–90 mg/kg per day	Non–type I: cefdinir, cefuroxime, cefpodoxime; type I: azithromycin, clarithro	Amoxicillin–clavulanate, 90 mg/kg per day of amoxicillin component, with 6.4 mg/kg per day of clavulanate	Non–type I: ceftriaxone, 3 days; type I: clindamycin
Yes	Amoxicillin–clavulanate, 90 mg/kg per day of amoxicillin, with 6.4 mg/kg per day of clavulanate	Ceftriaxone, 1 or 3 days	Amoxicillin, clavulanate, 90 mg/kg per day of amoxicillin, with 6.4 mg/kg per day of clavulanate	Ceftriaxone, 1 or 3 days	Ceftriaxone, 3 days	Tympanocentesis, clindamycin

Antimicrobial Prophylaxis for Recurrent OM

- **Still in debate!**
- Children < 2 years may benefit the most.
- If a child has had > = 3 episodes of AOM in 6 months or 4 episodes in 4 months, s/he should be considered a candidate for chemoprophylaxis.
- Give 1/2 the treatment dose of either amoxicillin or sulfonamides q daily over 6 months ideally during winter and spring.
- A new episode of AOM in a child receiving chemoprophylaxis should be managed with a different antibiotic.

What are the Treatment Options for AOM?

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