

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* |

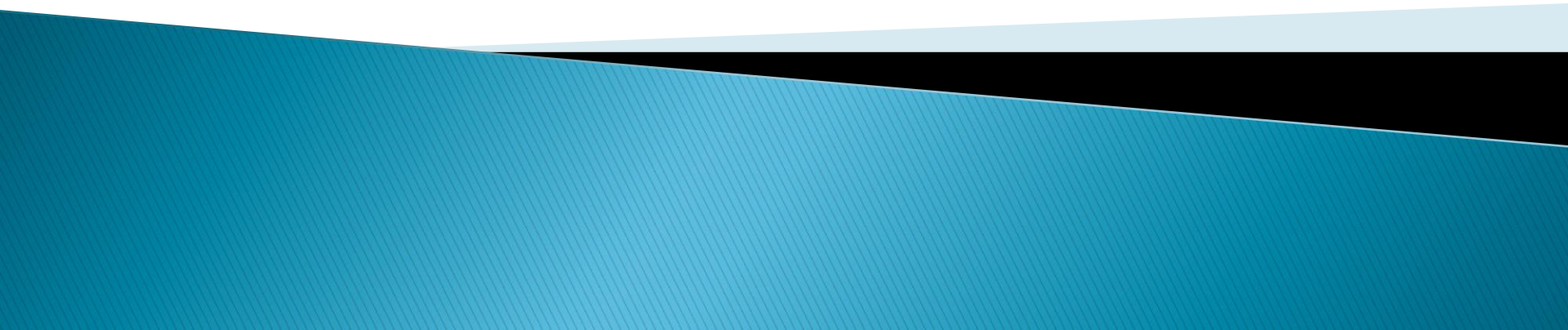
If the patient fails to respond to the initial management option within 48 to 72 hours, the clinician must reassess the patient to confirm AOM and exclude other causes of illness. If AOM is confirmed in the patient initially managed with observation, the clinician should begin antibacterial therapy.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

| Temperature 39°C and/or Severe Otitis | 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, cefepodoxime ; type I: azithromycin , clarithro | Amoxicillin, 80-90 mg/kg per day | Non-type I: cefdinir, cefuroxime, cefepodoxime ; 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 | Tympanocen- tisis, 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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