

Priorities of Clinical Assessment	History	RED FLAGS AND HIGH RISK GROUPS
<p>Most cases are due to a viral infection and will resolve without antibiotics</p> <p>Acute Otitis Media (AOM) is very common and peak age prevalence is 6-18 months</p> <p>Do not accept AOM as the sole diagnosis in a sick febrile young child. Other more serious causes need to be excluded</p> <p>Avoid routine use of antibiotics</p> <p>See also Febrile Child under 5 years pathway</p> <p>Exposure to cigarette smoke is a risk factor</p>	<p>Recent onset ear pain (irritability in preverbal children)</p> <p>Fever</p> <p>Loss of appetite</p> <p>Vomiting</p> <p>Lethargy</p> <p>Viral Symptoms (cough, sore throat)</p>	<p>Unwell/septic appearance</p> <p>Age < 6 months</p> <p>Cochlear Implants</p> <p>Immunocompromise</p> <p>Possible suppurative complications</p>
Examination		
<p>Tympanic Membrane (TM)</p> <p>On Otoscopic examination:</p> <ul style="list-style-type: none"> • Distinctly red, yellow, cloudy TM • Severe bulging with loss of landmarks and an air-fluid level • Perforation to TM or discharge in external auditory canal 	<p>Signs of systemically unwell</p> <p>Signs of associated viral infection</p> <ul style="list-style-type: none"> • Lymph nodes • Red throat • Coryzal <p>External Ear (for signs of otitis externa)</p> <ul style="list-style-type: none"> • Tender to examine • Look for redness or tenderness over mastoid • Skin of external ear canal swollen, painful, itchy 	

Investigation	Look out for	Management	Antibiotics	Complications	Send to hospital if
<ul style="list-style-type: none"> • There are no routine investigations for acute ear infection • Diagnostic imaging is only required if complications are suspected • Swab if purulent discharge out of one ear or recurrent infection 	<ul style="list-style-type: none"> • Alternative diagnosis • Sick or febrile young child • Red flags or complications 	<ul style="list-style-type: none"> • Simple analgesia (paracetamol, ibuprofen) • Short term use of topical analgesia can be used if there is an intact TM and severe pain • There is no role for decongestants, steroids or antihistamines in AOM 	<ul style="list-style-type: none"> • Antibiotics are not indicated in the vast majority of cases • For AOM worsening after 48 hours or where there are underlying health concerns or pus draining from the ear consider Amoxicillin as per the BNFC <p>Antibiotics may be indicated for</p> <ol style="list-style-type: none"> 1.AOM worsening after 48 hours 2.Where there are underlying health concerns 3.Frank pus from ear <p><i>Amoxicillin as per BNFC or Clarithromycin if true penicillin allergy</i></p>	<ul style="list-style-type: none"> • TM Perforation • Acute Mastoiditis – this requires prompt treatment and referral to ENT. It is diagnosed due to protruding auricle, erythema, oedema and tenderness or fluctuance in the post auricular region • Intracranial suppurative collection occurs but is rare • Facial nerve palsy associated with AOM should be discussed with ENT • Persistent effusion beyond 3 months should trigger a hearing assessment and ENT referral 	<ul style="list-style-type: none"> • Systemically unwell • Young infant where diagnosis is uncertain • Children with acute mastoiditis or cochlear implants should be discussed with ENT • Evidence or concern about complications