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AAO-HNSF Updated Clinical Practice Guideline: Otitis Media with Effusion

“Otitis media with effusion is a hazard of early childhood. Most kids will experience ear fluid by the time they are school age. This updated guideline includes more resources to help doctors better communicate with parents and caregivers, and emphasizes that while the ear fluid usually goes away on its own, follow up is still important.”

— Richard M. Rosenfeld, MD, MPH, guideline chair

What is otitis media with effusion (OME)?

- Otitis media with effusion (OME), or ear fluid, occurs in the middle ear. The middle ear is an air-filled space just behind the eardrum. When mucus or liquid builds up in this area, it is called OME.
- OME is different from an ear infection. Ear infections and OME both have fluid in the middle ear, but with OME, the fluid is not infected and usually there is little to no pain.
- OME may be caused by a cold, an ear infection, or poor eustachian tube function. It may be difficult to tell when a child has ear fluid because there may not be any symptoms. OME usually goes away on its own.

Why is the OME guideline important?

- About 90% of children have OME by 5 years of age. Approximately 2.2 million new cases are diagnosed annually in the United States at a cost of \$4.0 billion.
- OME is the most common cause of hearing impairment in children in developed nations, and the leading indication for ear tube insertion.
- Despite the frequency of OME, surveillance data suggest that a minority of clinicians follow clinical practice guidelines and some treat OME inappropriately with antibiotics, which results in unnecessary adverse events and bacterial resistance.

What is the purpose of the OME guideline?

- The purpose of this guideline is to identify quality improvement opportunities in managing OME and to create explicit and actionable recommendations to implement these opportunities in clinical practice.
- The guideline was updated by a multi-disciplinary panel of experts representing the disciplines of otolaryngology—head and neck surgery, pediatric otolaryngology, otology, pediatrics, allergy and immunology, family medicine, audiology, speech-language pathology, advanced practice nursing, and consumer advocacy.

What are significant points made in the guideline?

1. **A) Pneumatic otoscopy** – The clinician **should** document the presence of middle ear effusion with pneumatic otoscopy when diagnosing OME in a child.
B) Pneumatic otoscopy – The clinician **should** perform pneumatic otoscopy to assess for OME in a child with otalgia, hearing loss, or both.
2. **Tympanometry** – Clinicians **should** obtain tympanometry in children with suspected OME for whom the diagnosis is uncertain after performing (or attempting) pneumatic otoscopy.

3. **Failed newborn hearing screen** – Clinicians **should** document in the medical record counseling of parents of infants with OME who fail a newborn hearing screen regarding the importance of follow-up to ensure that hearing is normal when OME resolves and to exclude an underlying sensorineural hearing loss (SNHL).
4. **A) Identifying at-risk children** – Clinicians **should** determine if a child with OME is at increased risk for speech, language, or learning problems from middle ear effusion because of baseline sensory, physical, cognitive, or behavioral factors.
B) Evaluating at-risk children – Clinicians **should** evaluate at-risk children for OME at the time of diagnosis of an at-risk condition and at 12 to 18 months of age (if diagnosed as being at-risk prior to this time).
5. **Screening healthy children** – Clinicians **should not** routinely screen children for OME who are not at-risk and do not have symptoms that may be attributable to OME, such as hearing difficulties, balance (vestibular) problems, poor school performance, behavioral problems, or ear discomfort.
6. **Patient education** – Clinicians **should** educate families of children with OME regarding the natural history of OME, need for follow-up, and the possible sequelae.
7. **Watchful waiting** – Clinicians **should** manage the child with OME who is not at-risk with watchful waiting for three months from the date of effusion onset (if known) or three months from the date of diagnosis (if onset is unknown).
8. **A) Steroids** – Clinicians **should recommend against** using intranasal steroids or systemic steroids for treating OME.
B) Antibiotics – Clinicians **should recommend against** using systemic antibiotics for treating OME.
C) Antihistamines or decongestants – Clinicians **should recommend against** using antihistamines, decongestants, or both for treating OME.
9. **Hearing test** – Clinicians **should** obtain an age-appropriate hearing test if OME persists for three months or longer OR for OME of any duration in an at-risk child.
10. **Speech and language** – Clinicians **should** counsel families of children with bilateral OME and documented hearing loss about the potential impact on speech and language development.
11. **Surveillance of chronic OME** – Clinicians **should** reevaluate, at three- to six-month intervals, children with chronic OME until the effusion is no longer present, significant hearing loss is identified, or structural abnormalities of the eardrum or middle ear are suspected.
12. **A) Surgery for children less than 4 years old** – Clinicians **should** recommend tympanostomy tubes when surgery is performed for OME in a child less than 4 years old; adenoidectomy should not be performed unless a distinct indication (e.g., nasal obstruction, chronic adenoiditis) exists other than OME.
B) Surgery for children age 4 years old or older – Clinicians **should** recommend tympanostomy tubes, adenoidectomy, or both when surgery is performed for OME in a child 4 years old or older.
13. **Outcome assessment** – When managing a child with OME clinicians **should** document in the medical record resolution of OME, improved hearing, or improved quality of life (QOL).

About the AAO-HNS/F

The American Academy of Otolaryngology—Head and Neck Surgery (www.entnet.org), one of the oldest medical associations in the nation, represents about 12,000 physicians and allied health professionals who specialize in the diagnosis and treatment of disorders of the ears, nose, throat, and related structures of the head and neck. The Academy serves its members by facilitating the advancement of the science and art of medicine related to otolaryngology and by representing the specialty in governmental and socioeconomic issues. The AAO-HNS Foundation works to advance the art, science, and ethical practice of otolaryngology-head and neck surgery through education, research, and lifelong learning. The organization's vision: "Empowering otolaryngologist-head and neck surgeons to deliver the best patient care."