

REACH Notes

Recent Developments to Promote Judicious Antibiotic Prescribing

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Current Controversies: Watchful waiting for acute otitis media

Treatment of otitis media accounts for 60% of antibiotics received by young children. Some are giving new consideration to a “watchful waiting” approach for acute otitis media (AOM), rather than immediate antibiotic treatment of all cases. Watchful waiting rests on critical analysis of studies showing approximately 80% of acute otitis media resolves spontaneously,¹ and

and with mild acute otitis media, are given analgesics alone for the first 24-72 hours. If symptoms persist or worsen, antibiotic treatment is initiated. Some clinicians write a prescription to be filled if needed.

For which children is watchful waiting appropriate? Advocates of this approach in the US recommend it be used in children > 2 years with mild AOM, without other medical conditions, when follow-up is assured, and whose parents are comfortable with this approach. Mild AOM is defined as middle ear effusion (MEE) in the presence of signs of acute inflammation, but without severe pain, high fever, or a bulging tympanic membrane. Since this is not the standard approach in the US, documentation of parental understanding and consent is recommended.

Who uses watchful waiting? The large studies documenting its safety and effectiveness come from the Netherlands,² where it is the standard approach, with recent confirming studies from Britain. A campaign in New York State is encouraging this approach for children > 2 years. Other otitis media experts in the US do not support this option for acute otitis media, and it is not part of the 1997 CDC/AAP guidelines.³ Almost all agree that MEE without acute inflammation (OME) does not require treatment with antibiotics.

What are the benefits? Decreased antibiotic exposure for children will reduce common side effects such as diarrhea, and more serious drug reactions. The short-term risk of carriage of a resistant organism should be lower for the child, and lower antibiotic use rates may slow rise of resistance in our communities. A 75% decrease in antibiotics for AOM was found in one study.⁴

What are the risks? One recent study documented an average of 1 extra day of ear pain, and 0.5 extra spoons of Tylenol given, but no difference in episodes of distress or pain scores.⁴ Adequate analgesia is an important part of this approach. Complications of otitis media, including mastoiditis, are rare but important. There is debate about whether rates are higher in countries that use this approach, but even studies showing differences have estimated extremely small risks (2 per 100,000 compared to 4 per 100,000 population). For this reason, this approach is not recommended for children with moderate-severe AOM. Immediate treatment of worsening symptoms, and even mild symptoms persisting for 48 hours, should decrease these risks.

Finally, REACH Mass does not endorse any particular treatment option for individual patients. The decision to use this approach in selected cases must be left to individual clinicians in discussion with their patients. We will continue to provide information to physicians and parents so that they can make informed decisions regarding the use of antibiotics in community settings. REACH will also supply parent information sheets explaining this option upon request.

1. Takata GS, Chan LS, Shekelle P, Morton SC, Mason W, Marcy SM. Evidence assessment of management of acute otitis media: I. the role of antibiotics in treatment of uncomplicated acute otitis media. *Pediatrics* 2001; 108:239-247.
2. van Buchem FL, Peeters MF, van't Hof MA. Acute otitis media: a new treatment strategy. *BMJ* 1985; 290:1033-1037.
3. Dowell SF, Marcy SM, Phillips WR, Ge
4. Little P, Gould C, Williamson I, Moore M, Warner *Med.J* 2001; 322:336-342.