OTITIS EXTERNA REFERRAL GUIDELINE

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HIGH RISK

SUGGESTED EMERGENT CONSULTATION

SYMPTOMS AND LABS

Suspicion for malignant otitis externa
- spread of infection beyond the
ear canal, especially in diabetics or
immunocompromised host; look for
severe pain out of proportion to exam,
spread of edema/erythema beyond
the canal, cranial nerve abnormalities
(especially facial nerve weakness,
numbness, palatal asymmetry, tongue
deviation)

Suspicion for soft tissue abscess

SUGGESTED PREVISIT WORKUP

Ensure diabetes control

CBC with differential, ESR, CRP

initiate topical and systemic antibiotics with anti-Pseudomonal coverage

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND LABS

Failure to improve after 48 hours of routine topical management

inability to clear ear canal of debris that may affect topical antibiotic administration

Concern for middle ear disease, such as cholesteatoma or chronic otitis media-painless drainage, tympanic membrane retraction or perforation with or without drainage, history of tympanostomy tube placement or middle ear surgery

SUGGESTED WORKUP

Consider culture of ear canal purulence if failing topical therapy

Consider adding systemic antimicrobial therapy if significant soft tissue involvement out of the ear canal

LOW RISK

SUGGESTED ROUTINE CARE

SYMPTOMS AND LABS

Otherwise healthy patient with acute or sub-acute onset of ear canal edema, pain and purulence

Responding to topical antimicrobials in the first 48 hours

SUGGESTED MANAGEMENT

Topical antibiotics with or without steroid

If perforation unknown or suspected quinolone such as ciprofloxacin or ofloxacin, consider Ciprodex or CiproHC if significant edema

If no perforation- quinolone as above; or Cortisporin solution if no tympanic membrane perforation (potential for ototoxicity if access the inner ear via a perforation); or acetic acid with or without steroid (potential for ototoxicity as well)

Treatment with twice daily drop therapy for 7-10 days is recommended

Counsel patient to keep ear dry throughout treatment; over-the-counter ear plug or cotton ball rubbed in Vaseline can be used for showering; avoid submerging ear under water

Pain management is necessary as acute otitis externa is a very painful condition; occasionally, a short-term supply of narcotics is necessary if pain is sever; topical analgesic drops are not recommended

CLINICAL PEARLS

- 98% of acute otitis externa in North America is bacterial most common pathogens Pseudomonas aeruginosa (20%-60% prevalence) and Staphylococcus aureus (10% 70% prevalence); remaining 2-3% generally another gram-negative bacterium
- Fungal involvement is distinctly uncommon in primary AOE but may be more common in chronic otitis externa or after treatment of AOE with topical, or less often systemic antibiotics
- Anything that disrupts the epithelium of the ear canal can permit invasion by bacteria that cause diffuse AOE. Common predisposing factors for AOE are humidity or prolonged exposure to water, dermatologic conditions (eczema, seborrhea, psoriasis), anatomic abnormalities (narrow canal, exostoses), trauma or external devices (was removal, inserting earplugs,
- using hearing aids), and otorrhea caused by middle-ear disease. AOE may also occur secondary to ear canal obstruction by impacted cerumen, a foreign object, a dermoid cyst, a sebaceous cyst, or a furuncle
- 13% of normal volunteers are hypersensitive to neomycin, a component in Cortisporin drops
- Otalgia in the absence of swelling of the ear canal and without apparent middle ear disease should arouse suspicion of pathology outside the ear; particularly common in adults with a normal ear exam is temporomandibular joint (TMJ) syndrome. These patients commonly complain of pain not only in the ear but also radiating to the periauricular temple, or neck.

Maine Medical
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These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.

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