Otitis Media: Referral

Scope
This guideline is intended for all physicians who deal with patients with otitis media.

Clinical Question
When should patients with AOM and OME be referred to a specialist?

Clinical situations meriting consideration of subspecialty consultation or referral

Acute Otitis Media
1. Emergent/Urgent referral. Any suspected complications such as meningitis (medical emergency) or other intracranial complications facial weakness or paralysis, vertigo, or post-auricular swelling, redness, or displacement of the auricle (mastoiditis).**
2. Semi-urgent referral (2 to 3 days): Failure of antibiotic therapy with persistent severe signs and symptoms of AOM such as high fever or intractable pain (for consideration of diagnostic tympanocentesis).

Recurrent acute otitis media
1. Recurrent infections (over four documented infections in a year or three infections in six months).
2. Recurrent acute otitis media in a child with co-existing illnesses for which surgical treatment is desirable versus continued antibiotic therapy (e.g. immune deficiency, cystic fibrosis, sickle cell disease).
3. Recurrent infections with colonization with multi-resistant bacteria.
4. Recurrent infections and antibiotic allergies.
Chronic otitis media with effusion
1. Suspicion of hearing loss or history of language delay (audiology first).
2. Persistent middle ear effusion for 3-4 months.
3. Persistent tympanic membrane retraction or atelectasis.
4. Persistent abnormal tympanogram or audiogram
5. All children with cleft palate, Down Syndrome, or craniofacial malformations should be referred early rather than late.

Other
1. Cerumen impaction unresponsive to conservative management.
2. Suspicion of cholesteatoma.
3. Recurrent AOM and OME with history or symptoms of allergic disease

* In many cases, primary care physicians will be able to manage these conditions without referral.
** Fluid in the mastoid air cells on CT scan or X ray, without clinical evidence of mastoiditis, is common with AOM and is not, in itself, an indication for referral

Management options for OME
In the case of otherwise healthy children under age 2, two randomized studies comparing immediate to delayed ventilation tube placement for prolonged OME failed to show any significant benefit of early ventilation tube placement on later language development. Less than half of patients for whom tube placement was deferred in one of these studies ended up getting tubes by age 3. However, if a child is exhibiting significant speech delay or behavioural disruption or suffers from some other cause of sensory or cognitive dysfunction, early tube placement is probably appropriate. Children with anatomic abnormalities such as a bifid uvula, cleft palate, or Down Syndrome are less likely to resolve their MEE spontaneously and should also be referred for early intervention. In order to serve those patients who will eventually need tubes in a timely manner, it is appropriate to refer any child with a 3-4 month history of documented OME.