

Children and EAR INFECTIONS



Parents know the symptoms all too well: shrill crying, ear tugging, fussiness and fever.

By age three, more than 75 percent of children have experienced middle-ear infections, also known as acute otitis media (AOM).

Second only to well baby checkups as the reason for pediatric office visits, AOM can lead to episodes of what is medically known as otitis media with effusion (OME)—a condition in which fluid builds behind the eardrum, causing infection and severe pain. “OME is the most common cause of hearing loss in young patients,” says **Dr. Robin Steinberg-Epstein**, a UC Irvine Healthcare pediatrician.

The antibiotic question. But what’s the best way to treat this common ailment? Until recently, U.S. doctors wrote about 15 million prescriptions annually to treat ear infections—more than for any other childhood ailment. But revised clinical

guidelines released in 2004 by the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) are changing this approach. The two groups recommended antibiotics for ear infections in children under age two, as well as for those with severe ear pain and/or temperatures of 102.2 or more. Antibiotics were also recommended for all children whose AOM symptoms didn’t improve within 72 hours. But for those who don’t fall within these guidelines, the condition usually heals itself. To relieve discomfort during

the waiting period, ibuprofen, acetaminophen and warm compresses to the ear can help. “This change in perspective is based on a major study showing that a wait-and-see approach is as effective as antibiotics in resolving most childhood ear infections,” says Steinberg-Epstein. “The new guidelines also reflect doctors’ growing concern about antibiotic resistance.”

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Recommendations have also changed for children who have chronic OME—ear infections with fluid buildup that persist for months. “Fluid in the middle ear interferes with the way the eardrum and ear bones function,” says Steinberg-Epstein. “This can lead to various degrees of hearing loss—a particularly serious situation during the early years of language development when a child is learning to speak by listening.”

Ear tubes. In the past, ear tubes were the automatic and immediate answer to chronic OME. But today, this remedy also has been put on the wait-and-see list. In fact, the AAP, AAFP and American Academy of Otolaryngology-Head Neck Surgery recently recommended that children with OME simply be watched closely for three to six months without taking further measures. “In many cases, the ear fluid disappears on its own,” says Steinberg-Epstein. “But if the problem persists over a period of three months—or if there’s evidence of related hearing, speech or behavior problems—ear tubes should be considered.”

In addition to OME, there are many other causes of childhood hearing loss, ranging from pre-birth infections to head injuries and diseases such as bacterial meningitis. “Although the hearing of newborns is tested almost universally in hospitals throughout the nation, a lot can happen between birth and the time a child enters school,” says **Dr. Hamid Djalilian**, a UC Irvine Healthcare ear and hearing specialist. For this reason, experts urge parents to stay alert for hearing problems. By 4 months, a child should respond to a parent’s voice. By 9 months, babies should react to sound-making toys. By 16 months, babies should respond to their name and say at least three words such as “mama,” “dada,” or “ball.” And by 24 months, they should say between 100 and 200 words, follow simple commands, and speak in two-word sentences. Telltale signs that an older child has a potential hearing loss include problems at school, difficulty pronouncing words correctly, turning up the television volume excessively high, and asking “what?” or “huh?” repeatedly. For referral to a pediatrician or ear specialist, call 877.UCI.DOCS.



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