Chronic Suppurative Otitis Media

Chronic suppurative otitis media (CSOM) is a chronic inflammation of the middle ear and mastoid cavity. It is predominantly a disease of the developing world. Clinical features are recurrent otorrhoea through a tympanic perforation, with conductive hearing loss of varying severity. Experts dispute the duration of otorrhoea required to determine it as a chronic infection - the World Health Organization's definitions suggest more than two weeks\(^1\) whilst others contend longer (eg, up to six weeks)\(^2\).

The tympanic membrane is perforated in CSOM. If this is a tubotympanic perforation (in the centre of the tympanic membrane), it is usually 'safe', whilst atticoantral perforation (at the top of the tympanic membrane) is often 'unsafe'. Safe or unsafe depends on the presence of cholesteatoma:
- **Safe CSOM** is CSOM without cholesteatoma. It can be subdivided into active or inactive depending on whether or not infection is present.
- **Unsafe CSOM** involves cholesteatoma. Cholesteatoma is a non-malignant but destructive lesion of the skull base.

The underlying pathology of CSOM is an ongoing cycle of inflammation, ulceration, infection and granulation. Acute infection of the middle ear causes irritation and inflammation of the mucosa of the middle ear with oedema. Inflammation produces mucosal ulceration and breakdown of the epithelial lining. Granuloma formation can develop into polyps in the middle ear. This process may continue, destroying surrounding structures and leading to the various complications of CSOM.

**Epidemiology\(^1\)**
- In Britain, 0.9% of children and 0.5% of adults have CSOM, with no difference between the sexes.
- CSOM incidence rate is 4.76%, equating to 31 million cases, with 22.6% of cases occurring annually in the under-5s. 50% of CSOM patients have hearing impairment.
- Worldwide, there are between 65-330 million people affected, of whom 60% develop significant hearing loss. This burden falls disproportionately on children in developing countries\(^3\).
- There is an association between CSOM and poor educational performance\(^4\).

**Risk factors\(^2\)**
- Multiple episodes of acute otitis media (AOM).
- Living in crowded conditions.
- Being a member of a large family.
- Attending daycare.
- Studies of parental education, passive smoking, breastfeeding, socio-economic status and the annual number of upper respiratory tract infections (URTIs) show inconclusive associations only.
- Craniofacial abnormalities increase risk: cleft lip or palate, Down's syndrome, cri du chat syndrome, choanal atresia and microcephaly all increase the risk of CSOM.

**Spectrum of otitis media\(^5\)**
Otitis media (OM) is an umbrella term for a group of complex infective and inflammatory conditions affecting the middle ear. All OM involves pathology of the middle ear and middle ear mucosa. OM is a leading cause of healthcare visits worldwide and its complications are important causes of preventable hearing loss, particularly in the developing world\(^3\).

There are various subtypes of OM. These include acute otitis media, otitis media with effusion (OME), CSOM, mastoiditis and cholesteatoma. They are generally described as discrete diseases but in reality there is a great degree of overlap between the different types. OM can be seen as a continuum of diseases:
- **AOM** is acute inflammation of the middle ear and may be caused by bacteria or viruses. A subtype of AOM is acute suppurative OM, characterised by the presence of pus in the middle ear. In around 5% of cases the eardrum perforates.
- **OME** is a chronic inflammatory condition without acute inflammation, which often follows a slowly resolving AOM. There is an effusion of glue-like fluid behind an intact tympanic membrane in the absence of signs and symptoms of acute inflammation.
- **CSOM** is long-standing suppurative middle ear inflammation, usually with a persistently perforated tympanic membrane.
- **Mastoiditis** is acute inflammation of the mastoid periosteum and air cells occurring when AOM infection spreads out from the middle ear.
- **Cholesteatoma** occurs when keratinising squamous epithelium (skin) is present in the middle ear as a result of tympanic membrane retraction.
Presentation

Symptoms
- CSOM presents with a chronically draining ear (>2 weeks), with a possible history of recurrent AOM, traumatic perforation, or insertion of grommets.
- The otorrhea should occur without otalgia or fever.
- Fever, vertigo and otalgia should prompt urgent referral to exclude intratemporal or intracranial complications.
- Hearing loss is common in the affected ear. Ask about the impact of this on speech development, school or work. Mixed hearing loss (conductive and sensorineural) suggests extensive disease.

Signs
- The external auditory canal may possibly be oedematous but is not usually tender.
- The discharge varies from fetid, purulent and cheese-like to clear and serous.
- Granulation tissue is often seen in the medial canal or middle ear space.
- The middle ear mucosa seen through the perforation may be oedematous or even polypoid, pale, or erythematous.

This photo shows a large central tympanic membrane perforation, which is dry and thus ‘safe’. The picture to the right shows the successful results of a graft repair of the perforation:

(Image source: Open-i - see Further reading reference below)

This photo shows the more serious condition: chronic mucous discharge through a large central perforation. This is the appearance of chronic suppurative otitis media:

(Image source: Open-i - see Further reading reference below)
Differential diagnosis

- **Otitis externa** (inflamed, eczematous canal without a perforation).
- Foreign body.
- **Impacted earwax**.
- Cholesteatoma.
- Granulomatosis with polyangiitis (Wegener’s granulomatosis).
- Neoplasm.

**NB**: chronic **serous** otitis media is not the same as chronic **suppurative** otitis media. The former may be defined as a middle ear effusion, without perforation, persisting for more than 1-3 months.

Investigations

- *Do not* swab the ear in primary care, as the clinical utility of this is uncertain.
- An audiogram will normally show conductive hearing loss. Mixed hearing loss may suggest more extensive disease and possible complications.
- Imaging studies may be useful:
  - CT scanning for failed treatment may show occult cholesteatoma, foreign body or malignancy. It may be particularly helpful pre-operatively.[7]
  - A fine-cut CT scan can reveal bone erosion from cholesteatoma, ossicular erosion, involvement of petrous apex and subperiosteal abscess.
  - MRI is better if intratemporal or intracranial complications are suspected. It shows soft tissues better and can reveal dural inflammation, sigmoid sinus thrombosis, **labyrinthitis** and extradural and intracranial abscesses.

Management

**Primary care**

- If there is postauricular swelling or tenderness (suggesting **mastoiditis**), facial paralysis, vertigo or evidence of intracranial infection, arrange urgent assessment or admission with an ENT team.
- Refer cases of CSOM without these features for routine ENT assessment. An ENT specialist will be able to microsuction the exudate from the ear canal and hence visualise the tympanic membrane accurately.
- Current guidance from the National Institute for Health and Care Excellence Clinical Knowledge Summaries suggests that GPs should not initiate treatment - this is because few non-specialists have the equipment or training to carry out aural cleaning; additionally, the topical antibiotics used by specialists are either used off-licence (quinolones) or are not recommended in the presence of tympanic perforation (aminoglycosides).
- Patients should be advised to keep the affected ear dry.

**Swimming advice**

Patients with CSOM are usually advised to avoid swimming but, if they swim, they should dry their ears afterwards. Evidence is limited and there is consequently no consensus among specialists. Some advise ear plugs until grommets are extruded whilst others do not. Likewise, there is no agreement about whether diving should or should not be permitted whilst grommets are in situ.[8]

**Secondary care**

Conservative treatment of CSOM consists of three components:

- An appropriate antibiotic, usually given topically.
- Regular intensive aural toilet (microsuction) to remove debris.
- Control of granulation tissue.

**Medication**

- Aural toilet and topical antibiotics appear effective at resolving otorrhoea. Long-term outcomes (eg, healing of tympanic perforation, recurrence prevention and hearing improvement) need further study.
- Topical treatment is more effective at clearing aural discharge than systemic therapy.[9] - probably due to the higher local concentrations of antibiotic achieved.
Antibiotics should have activity against Gram-negative organisms, particularly pseudomonas and Gram-positive organisms, especially *Staphylococcus aureus*:

- Aminoglycosides and the fluoroquinolones both meet these criteria but there remain safety concerns with both. Many authorities advise that topical aminoglycosides should not be used with tympanic perforation, due to their ototoxicity. However, many specialists continue to use them carefully, considering that undertreated OM carries a higher risk of hearing impairment and complications[10].
- Topical quinolones are effective compared to no drug treatment or topical antiseptics only; however, evidence for their superiority over other topical antibiotics is only indirect[11]. UK specialists use either off-licence quinolones or aminoglycosides (because their effectiveness outweighs the risks of ototoxicity). There are specific concerns about the use of fluoroquinolones in children because of juvenile animal studies indicating a risk of joint injury in the young. Short-term treatment has been shown to be safe[12]. One study did find an association between ciprofloxacin and arthropathy in paediatric patients although the effect was reversible. No link was found between duration of administration and frequency of arthropathy[12].
- Antibiotic failure is usually due to failure to penetrate the debris rather than to bacterial resistance.

- Topical steroids are used to reduce granuloma formation and it is conventional to use combined antibiotic/steroid preparations.
- Systemic therapy is reserved for failure to respond to topical therapy. If a focus of infection in the mastoid cannot be reached by topical drops, then systemically administered antibiotics (usually IV) can penetrate in sufficient concentrations to control or eliminate infection. Topical therapy is continued simultaneously. This is usually done in hospital with an accompanying regime of intensive aural toilet.
- Treatment should continue for three to four weeks after the end of otorrhoea.

### Surgical

- There is a paucity of up-to-date evidence of surgical procedures for CSOM[13].
- However a small case series from India suggested that surgery can usually render an ear 'dry' and hence cured of the CSOM, when other treatments have failed[14].
- The type of surgery will depend on the severity of the disease process and may involve myringoplasty (repair of the eardrum perforation alone) or tympanoplasty (repair of the eardrum and surgery involving the bones of the inner ear).
- If otoscopy reveals granulation tissue of the unsafe variety, aural polyps or infection persisting despite appropriate medical treatment, cholesteatoma should be sought. The goal of ensuing treatment is to create a safe ear, although the appropriate surgical procedure is often controversial.
- If cholesteatoma is present (unsafe CSOM), classical radical mastoidectomy, modified radical mastoidectomy or the 'combined approach tympanoplasty' (anterior tympanotomy plus extended mastoidectomy) may be used depending on the extent of cholesteatoma and, more importantly, the experience of the surgeon. Whatever the procedure chosen, the aim of surgery is to remove all disease and to give the patient a dry and functioning ear.
- Facial paralysis can occur with or without cholesteatoma. Surgical exploration with mastoidectomy should be undertaken promptly.
- Labyrinthitis occurs when infection has spread to the inner ear. Early surgical exploration to remove the infection reduces damage to the labyrinth. Aggressive surgical debridement of the disease (including labyrinthectomy) is undertaken to prevent possibly fatal meningitis or encephalitis.
- Where conductive hearing loss has resulted from CSOM (due to perforation of the tympanic membrane and/or disruption in the ossicular chain), surgical removal of the infection and cholesteatoma, followed by ossicular chain reconstruction, will reduce hearing loss.
- Cochlear implants have been used in CSOM but it is essential to eradicate all disease first[15].

### Complications[16]

Complications of CSOM are rare but potentially life-threatening.

#### Intratemporal complications include:

- Petrositis
- Facial paralysis[17]
- Labyrinthitis

#### Intracranial complications include:

- Lateral sinus thrombophlebitis
- Meningitis
- Intracranial abscess

#### Sequelae include:

- Hearing loss
- Tymanosclerosis
Prognosis

Prognosis is good in developed countries where there is easy access to antibiotics and surgical treatment. However, in undeveloped countries the outcome can be variable. Otitis media caused 3,599 deaths worldwide in 2002, most cases due to spreading mastoid and intracranial infection.

Tympanic membrane perforations can heal spontaneously but can occasionally persist, leading to mild to moderate hearing impairment. If this occurs in the first two years of life, it is associated with an increase in learning disabilities and a decrease in educational performance.

Further reading & references

1. Chronic suppurative otitis media - burden of illness and management options; World Health Organization, 2004
6. Otitis media – chronic suppurative; NICE CKS, September 2017 (UK access only)
10. Llor C, McNulty CA, Butler CC; Ordering and interpreting ear swabs in otitis externa. BMJ. 2014 Sep 1;349:g5259.

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