Acute Otitis Media in Adults

Acute otitis media (AOM) is common in children but much less so in adults. Where the aetiology is bacterial, *Haemophilus influenzae* and *Streptococcus pneumoniae* are the most common organisms found, with the former organism dominating more since more widespread pneumococcal vaccination was introduced. Rhinoviruses and respiratory syncytial viruses are the main viral pathogens in adults as well as in children.\[1,2\]

**Spectrum of otitis media**[3]

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.\[4\]

There are various subtypes of OM. These include AOM, OME, chronic suppurative otitis media (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/spectrum 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% 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.

**Epidemiology**[2]

- AOM is seen frequently in children but is less common in adults. The incidence in adults is widely quoted as 0.25% per annum.\[1\]
- Smoking is a recognised risk factor.\[1\]
- Otitis media (OM) occurs more in the winter than in the summer months, as it is usually associated with a cold.\[5\]
- AOM is a particular issue in the developing world. A 2012 literature review suggested that the annual global incidence of AOM is 10.85%, comprising around 709 million cases per year, about half in under-5s. Incidence varies by a factor of ten or more between high-income and low-income countries. Of these, chronic suppurative OM develops in 4.76%. The authors estimated that 33 per 10 million die due to complications of OM, most in developing countries and most under 1 year of age.\[6\]

**Risk factors**

Risk factors in adults are similar to those in children:

- Eustachian tube dysfunction.
- Upper respiratory infection.
- Allergies.
- Chronic sinusitis.
- Craniofacial abnormalities - eg, cleft palate, Down's Syndrome.
Presentation[2]

The symptoms and signs are very similar to those of AOM seen in childhood, with hearing loss, otalgia and fever. In adolescents and adults, otalgia is a more common presenting symptom than in children under the age of 2.[1] Indeed, in adults, otalgia may occur without fever or hearing loss and may be the only presenting feature.

See separate Acute Otitis Media in Children, Otolgia (Earache) and Deafness in Adults articles for more details.

Differential diagnosis

This is essentially as for AOM in children. However, in adults temporomandibular joint dysfunction and associated differential diagnoses should be considered. These might include:

- Giant cell arteritis.
- Cardiac pain (angina and acute coronary syndromes) which can radiate to the neck and jaw but is usually more acute.
- Dental problems, including ill-fitting dental appliances.
- Trigeminal neuralgia.
- Migraine and other causes of headache.
- Herpes zoster.
- Trauma.
- Other ENT disorders - eg, salivary gland disorders and ENT neoplasms.

See separate Temporomandibular Joint Dysfunction and Pain Syndromes article for more details.

Investigations[2]

- As with AOM in children, investigations in the acute phase are unlikely to be helpful.
- Culture of discharge may be helpful if chronic perforation is suspected.
- CT or MRI scanning may be indicated to exclude complications (however, complications in adults are rare - see below).
- Tympanocentesis (piercing of the eardrum to obtain fluid from the middle ear) may be indicated in certain situations (eg, patients who are immunocompromised, or where local or systemic complications have developed as a result of antimicrobial failure).

Treatment[1, 2]

- Analgesics and antipyretics should be used as appropriate.
- Antibiotic guidelines are as for children.
- Nasal and oral steroids are sometimes indicated for adults with persistent AOM against a background of allergies.
- More invasive interventions - eg, myringotomy - are virtually unheard of in adults since the advent of antibiotics.

Admit for immediate assessment

- Patients with suspected acute complications of AOM, such as meningitis, mastoiditis, or facial nerve paralysis.

Consider admitting

- People who are systemically very unwell.
For all other people with AOM

- Treat pain and fever with paracetamol or a non-steroidal anti-inflammatory drug (NSAID) such as ibuprofen.
- For most people, adopt a no antibiotic prescribing strategy, or a delayed antibiotic prescribing strategy:
  - No antibiotic prescribing strategy - reassure that antibiotics are likely to make little difference to symptoms but may have adverse effects and can contribute to antibiotic resistance.
  - Delayed antibiotic prescribing strategy - provide a delayed antibiotic prescription. Advise that antibiotics should be started if symptoms are not improving within four days of onset of symptoms or if there is a significant worsening at any time.
  - For both strategies, advise review if the condition worsens or if symptoms are not improving within four days of the onset of symptoms.

Offer an immediate antibiotic prescription

- To patients who are systemically unwell but do not require admission.
- To those at high risk of complications because of significant heart, lung, kidney, liver or neuromuscular disease, or to those who are immunocompromised.
- To those whose symptoms have lasted for four days or more and are not improving.

If an antibiotic is required:

- Prescribe a five-day course of amoxicillin.
- For people who are allergic to penicillin, prescribe a five-day course of erythromycin or clarithromycin.[7]

Other treatments

- Antihistamines, decongestants and echinacea are of no benefit.[8]
- A warm compress over the affected ear may help reduce the pain.

If an episode of AOM fails to improve or worsens

- Reassess and re-examine.
- Admit for immediate specialist assessment, people with suspected acute complications of AOM (eg, meningitis, mastoiditis).
- Consider admitting people who are systemically very unwell.
- Exclude other causes of middle ear inflammation.
- If admission or referral is not necessary and the person has not taken an antibiotic:
  - Prescribe a five-day course of amoxicillin.
  - For people who are allergic to penicillin, prescribe a five-day course of clarithromycin or erythromycin.
- If admission or referral is not necessary and the person has been taking a first-line antibiotic, offer a second-line antibiotic:
  - Prescribe a five-day course of co-amoxiclav.
  - If allergic to penicillin, check your local guidelines.
- If symptoms persist despite two courses of antibiotics, seek specialist advice from an ENT specialist.

Treatment of recurrent AOM

- Refer urgently to an ENT specialist if nasopharyngeal cancer (rare) is suspected in adults, especially in the presence of any one of the following:
  - Persistent symptoms not responding to treatment.
  - Persistent cervical lymphadenopathy.
  - Unilateral epistaxis.
Consider routine referral to an ENT specialist, especially if:
- The person has a craniofacial abnormality.
- Recurrent episodes are very distressing or associated with complications.

If referral is not necessary:
- Manage acute episodes in the same way as for initial presentation.

**Complications**[^1,^2,^9]

As with children, common complications include:

- Tympanic membrane perforation.
- **Chronic suppurative OM**.
- OME.

AOM can be complicated by infratemporal and intracranial infection. These are conditions of significant morbidity. However, the incidence of severe complications is much lower in adults (one in 100,000 children compared to one in 300,000 adults per year).

Most (around 80% of) severe complications are infratemporal (mainly mastoiditis). The remaining severe complications are intracranial (mainly intracranial abscess and meningitis). Most severe complications are due to acute rather than chronic OM. Around 1 in 4 of cases of complications resulted in permanent hearing loss.

Severe complications include:

- **Infratemporal**:
  - Mastoiditis.
  - Facial nerve palsy.
  - Acute labyrinthitis.
  - Petrositis.
  - Acute necrotic otitis.

- **Intracranial**
  - Meningitis.
  - Encephalitis.
  - Brain abscess.
  - Otitic hydrocephalus (hydrocephalus associated with AOM, usually accompanied by lateral sinus thrombosis but the exact pathophysiology is unclear).
  - Subarachnoid abscess.
  - Subdural abscess.
  - Sigmoid sinus thrombosis.

Rarely, systemic complications can occur, including:

- Bacteraemia.
- Septic arthritis.
- **Bacterial endocarditis**.

One study in Taiwan found that adults who developed OM had an eleven-fold increase in nasopharyngeal cancer and recommended a five-year follow-up of all patients. However, it was not known whether this applied to countries in which the national prevalence of nasopharyngeal cancer was low.[^10]

OME rarely develops in adults (in children it tends to follow AOM when the Eustachian tubes have not drained properly). In adults it is more likely to signify underlying Eustachian tube dysfunction than preceding AOM. It usually follows a significant upper respiratory tract infection such as **sinusitis**. However, other possible underlying factors include:

- Severe nasal septal deviation.
- Large tonsils and adenoids.
Middle ear fluid in adults should therefore be treated as suspicious, particularly if unilateral.\(^1\)

**Prognosis**\(^2\)

With the exception of the few complications given above, there is usually complete resolution in a few days.

**Prevention**

In recurrent otitis media (either three or more acute infections of the middle ear in a six-month period, or at least four episodes in a year) strategies for managing the condition include the assessment and modification of risk factors where possible, repeated courses of antibiotics for each new infection and antibiotic prophylaxis. The latter should not be started without specialist advice.

Advise patients on avoiding exposure to passive smoking.

**Further reading & references**

- **Otitis externa; NICE CKS, August 2012 (UK access only)**
- **Otitis media with effusion; NICE CKS, March 2011 (UK access only)**
- **Otitis media - chronic suppurative; NICE CKS, January 2013 (UK access only)**

2. Otitis media - acute; NICE CKS, March 2015 (UK access only)
7. Managing common infections: guidance for primary care; Public Health England, August 2015

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