

Myths and Misconceptions: Pediatric Otolaryngology

CDR Matthew T. Brigger, MD, MPH
Pediatric Otolaryngology

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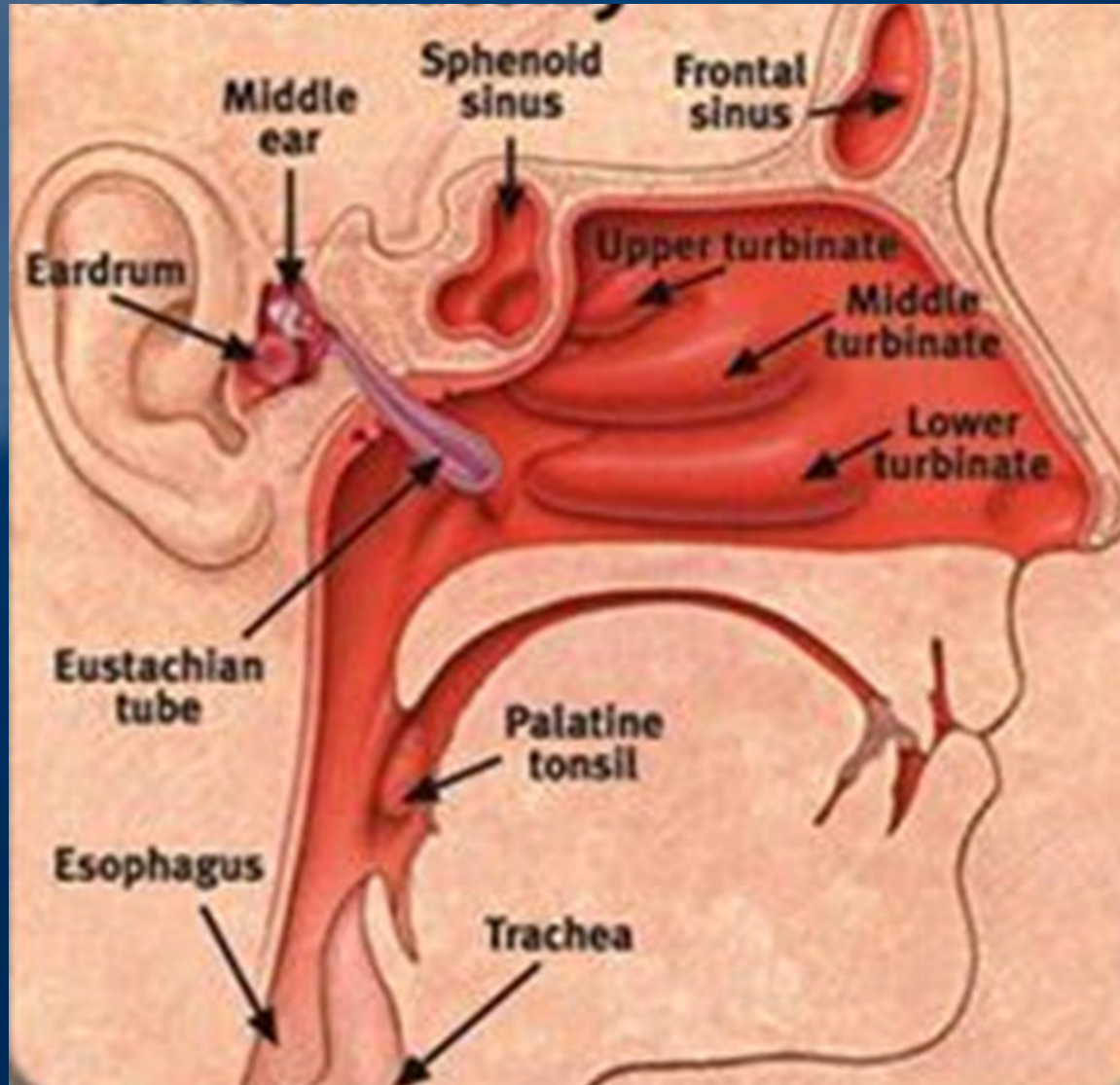
Disclosures

- None

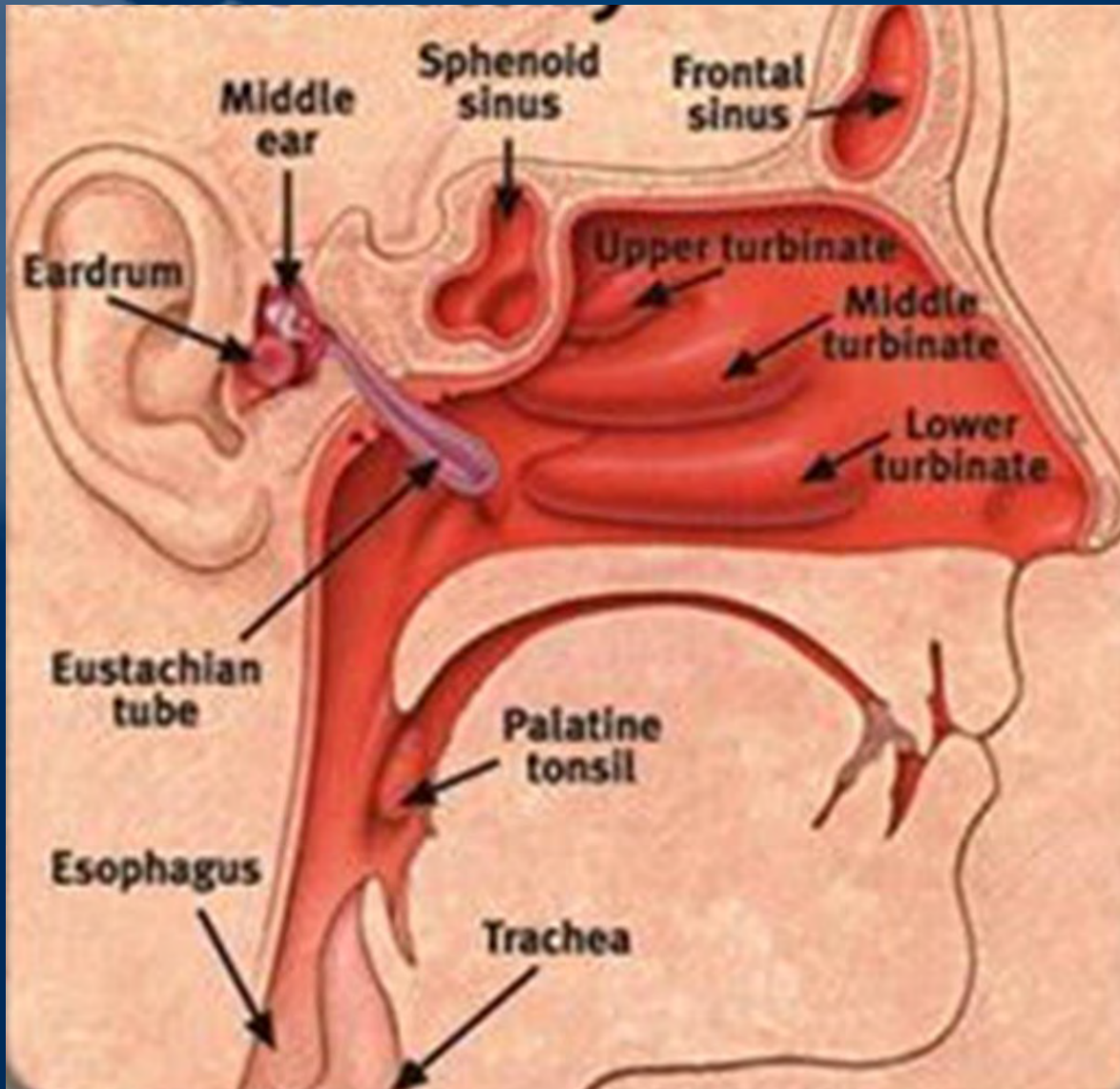
Objectives

- Understand candidacy and postoperative management of ear tubes
- Understand how to evaluate and treat epistaxis
- Understand when and what imaging is appropriate for the child with sinusitis
- Understand when to refer for tonsillectomy and what to expect postoperatively

Otorhinolaryngology



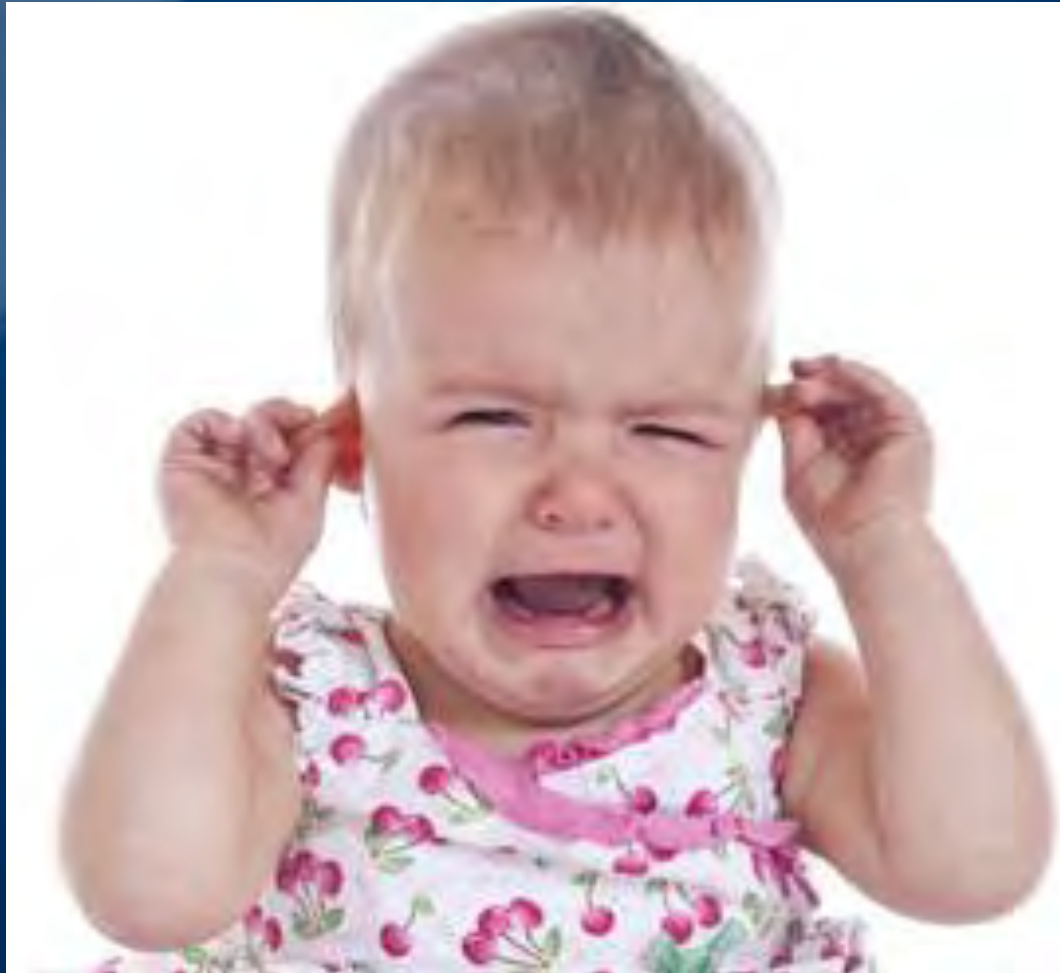
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Lets start with the E



What you see



What I see



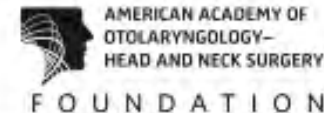
Who gets tubes?



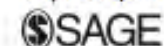
Guideline

Clinical Practice Guideline: Tympanostomy Tubes in Children

**Richard M. Rosenfeld, MD, MPH¹, Seth R. Schwartz, MD, MPH²,
Melissa A. Pynnonen, MD, MSc³, David E. Tunkel, MD⁴,
Heather M. Hussey, MPH⁵, Jeffrey S. Fichera, PA-C⁶,
Alison M. Grimes, AuD⁷, Jesse M. Hackell, MD, FAAP⁸,
Melody F. Harrison, PhD⁹, Helen Haskell, MA¹⁰,
David S. Haynes, MD¹¹, Tae W. Kim, MD¹², Denis C. Lafreniere, MD¹³,
Katie LeBlanc, MTS, MA¹⁴, Wendy L. Mackey, APRN¹⁵,
James L. Netterville, MD¹⁶, Mary E. Pipan, MD¹⁷,
Nikhila P. Raol, MD¹⁸, and Kenneth G. Schellhase, MD, MPH¹⁹**



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At the minimum who gets tubes?

- OME for 3 months AND
 - Documented hearing difficulties OR
 - Balance problems, poor school performance, behavioral problems, ear discomfort, or reduced quality of life.
- Recurrent AOM (3 infections in 6 months or 4 in 12 months) AND
 - ear effusion at time of exam

Now what?



Swimming is OK!



Otorrhea



AKA Ear Goop



What to do?

A. Observation

B. Ear irrigation

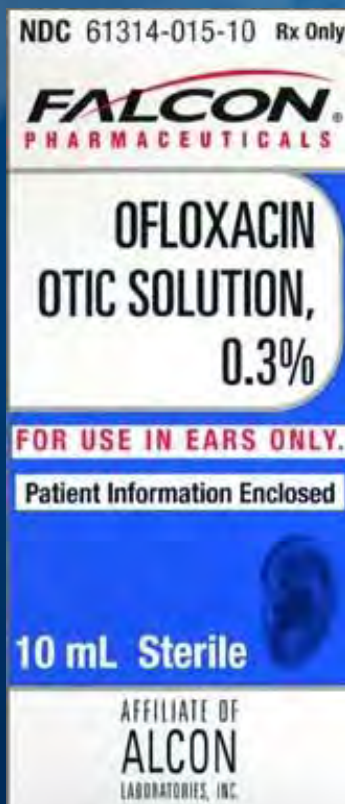
C. Topical antibiotic ear drops

D. Oral antibiotics

E. Both C & D

Tube Otorrhea

- Topical therapy alone



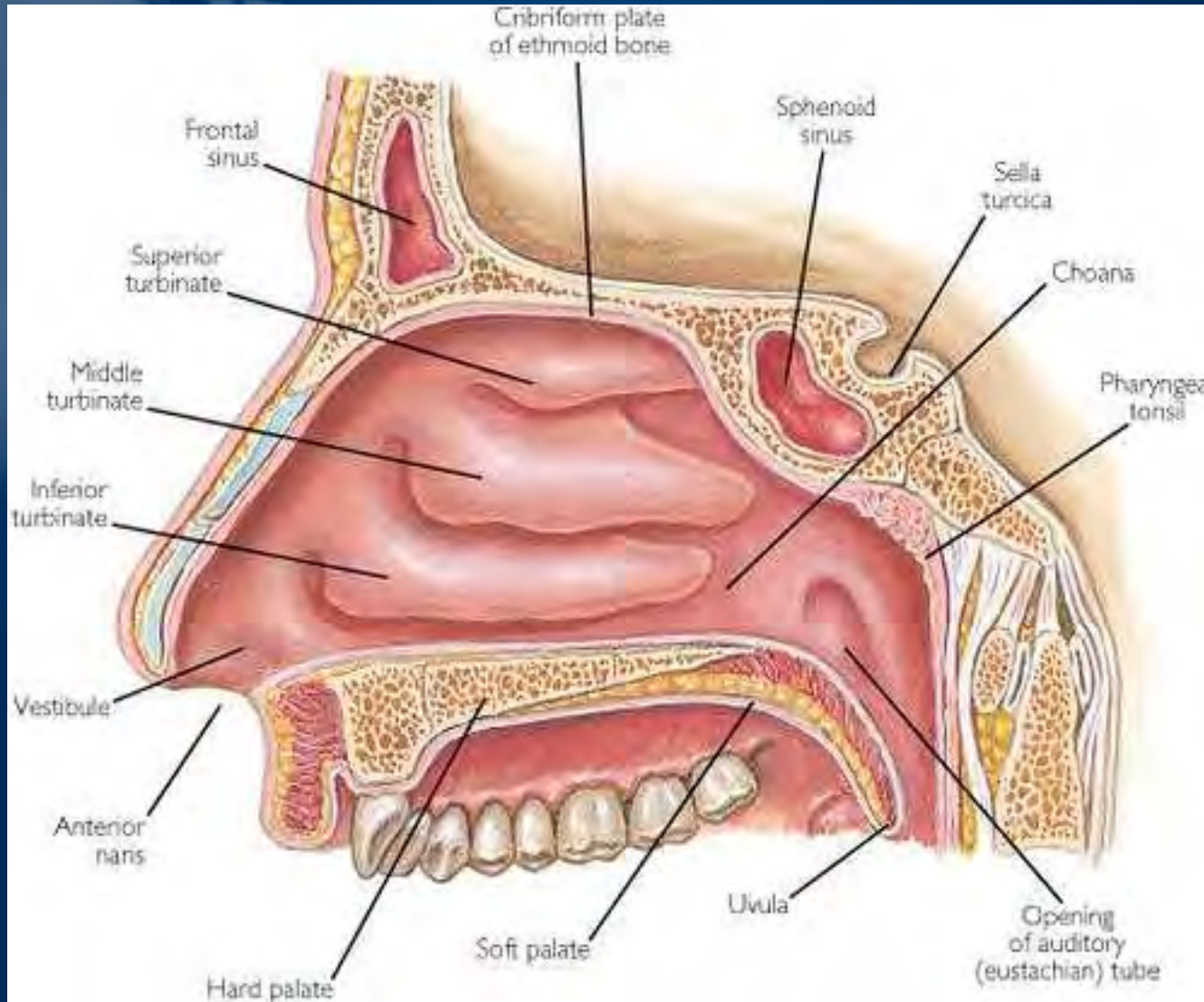
If the otorrhea is bloody...



If it won't go away

- Send back to us...
- Generally do not start oral antibiotics

On to the N



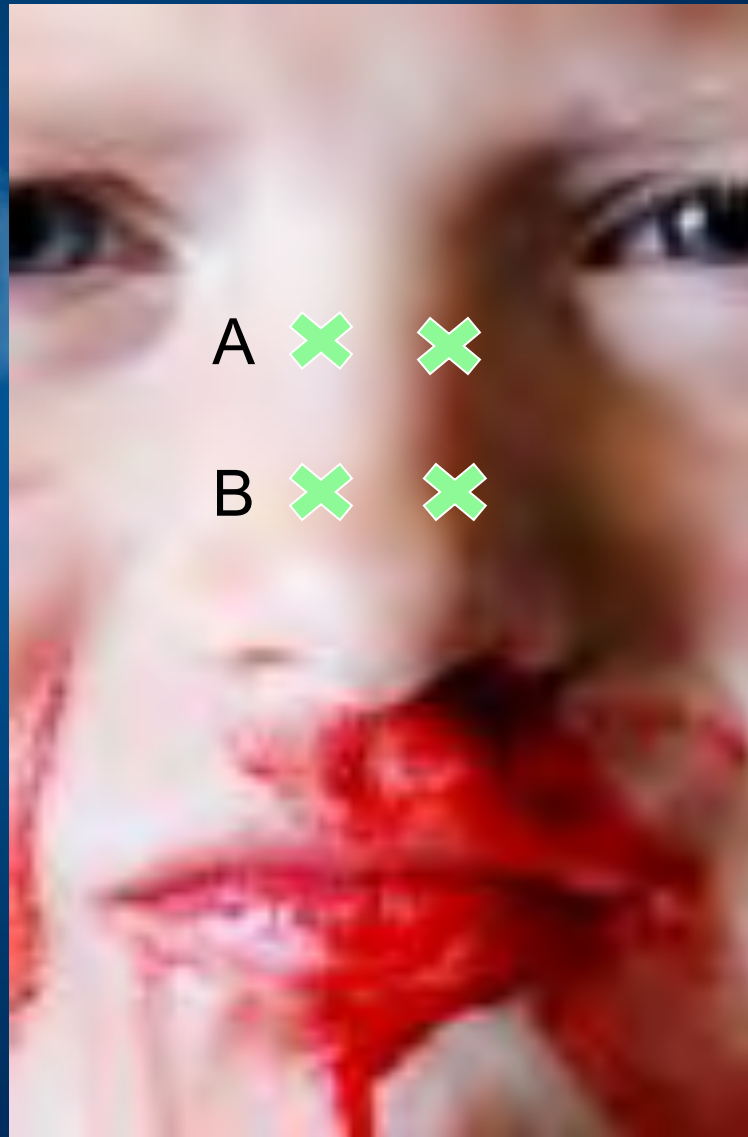
Start with a favorite

Myths and Misconceptions in Pediatric Otolaryngology



Where to pinch?

- A
- B



What position?



Afrin?

How long?

- 3-5 days maximum
- Avoid in children under 6

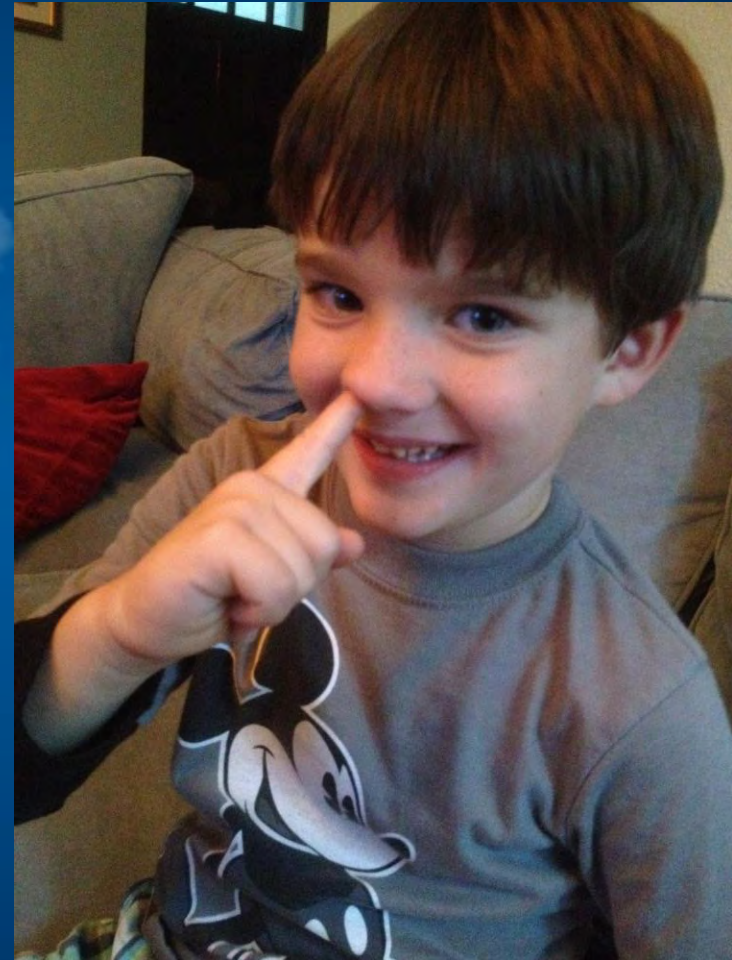
Prevention

- Keep moist
 - Saline nasal gel/spray
 - Humidifier



Prevention

- Avoid irritation
 - Nose picking
 - If allergies are a problem, an antihistamine is OK
 - Avoid nasal steroids



What about sinusitis?



Some Definitions

Acute bacterial sinusitis : Bacterial infection of the paranasal sinuses lasting less than 30 days in which symptoms resolve completely.

Subacute bacterial sinusitis : Bacterial infection of the paranasal sinuses lasting between 30 and 90 days in which symptoms resolve completely.

Recurrent acute bacterial sinusitis : Episodes of bacterial infection of the paranasal sinuses, each lasting less than 30 days and separated by intervals of at least 10 days during which the patient is asymptomatic.

Chronic sinusitis : Episodes of inflammation of the paranasal sinuses lasting more than 90 days. Patients have persistent residual respiratory symptoms such as cough, rhinorrhea, or nasal obstruction.

Acute bacterial sinusitis superimposed on chronic sinusitis : Patients with residual respiratory symptoms develop new respiratory symptoms. When treated with antimicrobials, these new symptoms resolve, but the underlying residual symptoms do not.¹⁴

Xrays?



 **Choosing
Wisely**[®]

What about a CT?



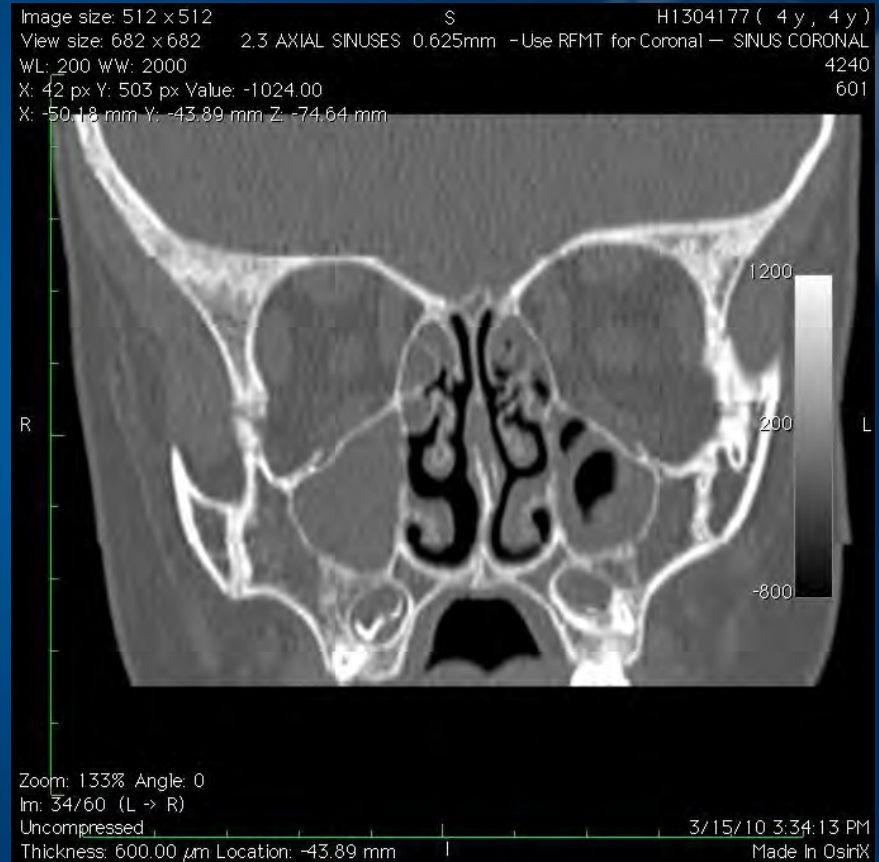
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Don't order sinus computed tomography (CT) or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis.

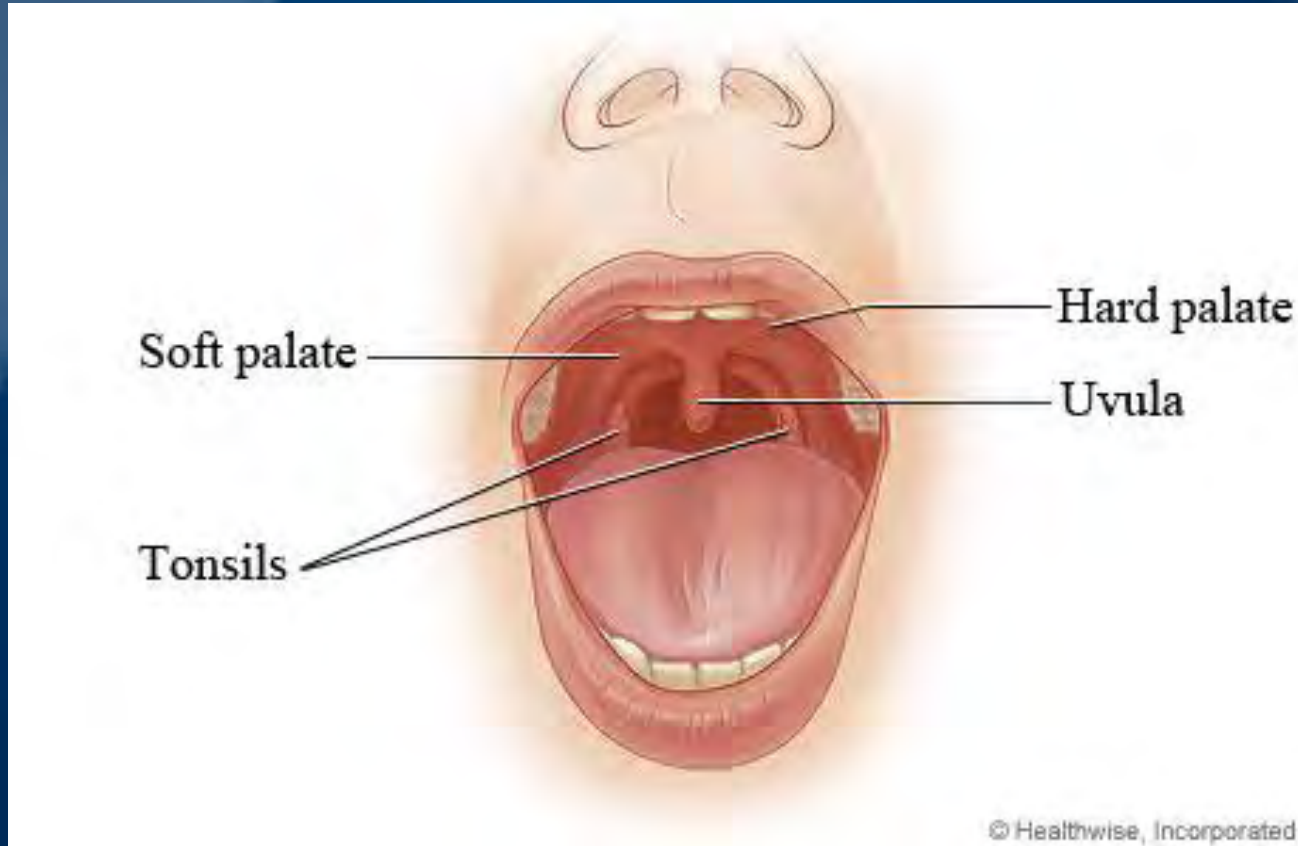
Viral infections cause the majority of acute rhinosinusitis and only 0.5 percent to 2 percent progress to bacterial infections. Most acute rhinosinusitis resolves without treatment in two weeks. Uncomplicated acute rhinosinusitis is generally diagnosed clinically and does not require a sinus CT scan or other imaging. Antibiotics are not recommended for patients with uncomplicated acute rhinosinusitis who have mild illness and assurance of follow-up. If a decision is made to treat, amoxicillin should be first-line antibiotic treatment for most acute rhinosinusitis.

Who needs a CT?

- If we are considering surgery



Now time for the T



Now time for the T



Focus on the tonsils



Indications for removal

- Two primary reasons
 - Obstructive sleep disordered breathing
 - The most common
 - Infectious
 - Recurrent acute vs. chronic tonsillitis
- “Other” reasons

Sleep Study?

Not necessary for healthy children with 3 strikes

✓ Nighttime symptoms

- Snoring, apneas, restless sleep, enuresis, night terrors

✓ Daytime symptoms

- hyperactivity, attention deficits, emotional lability, poor weight gain, temperamental, daytime somnolence

✓ Correlation to physical exam

- Adenotonsillar hypertrophy

Sleep Study?

General consideration guidelines

- Craniofacial, neuromuscular or systemic anomalies
- Increased risk (bleeding disorder, cardiac anomalies)
- Symptoms not congruent with exam
- Morbid obesity

Infectious causes

“classic” indications (Paradise 1984)

– Recurrent pharyngitis occurring:

- 7x/year for 1 year
- 5x/year for 2 years
- 3x/year for 3 years

≥ 2 weeks missed school in a year

Recurrent peritonsillar abscesses

“Others”

- 4+ tonsils causing dysphagia
- Speech abnormalities (velopharyngeal insufficiency)
- Neoplasm (unilateral hyperplasia, post transplant lymphoproliferative disorder)
- PFAPA (Periodic fevers with aphthous stomatitis, pharyngitis and adenitis)
- IgA nephropathy

Now that they are out...

- Short term (first 2 weeks)
 - Variable pain (including the ears)
 - We try to avoid narcotics
 - Bleeding is not normal
 - Bad breath is expected from the adenoids
- Long term
 - Sleep disordered breathing is not always cured
 - Strep pharyngitis is still possible

Take Home Points

- Swimming after ear tubes does not require ear plugs
- Simple ear tube otorrhea is treated topically
- Look down and pinch the tip for nose bleeds
- No imaging for uncomplicated sinusitis (and never order plain films)
- Sleep studies are not for healthy children with three strikes

Questions?

Thank You!

Matthew Brigger, MD
Pediatric Otolaryngology

mbrigger@rchsd.org

858-309-7701