Pediatric ENT Guidelines    Jane Cooper, FNP, CORLN

References:


Clinical Practice Guideline for the Diagnosis and Management of Acute Bacterial Sinusitis in Children aged 1-18 years   Wald et al, Pediatrics originally published online 6/24/2013. DOI:10.1542/peds.2013-1071
Pediatric ENT Guidelines- review the highlights

Clinical practice guidelines-Tympanostomy tubes in Children (Rosenfeld et al., 2013)

Summary of guideline action statements

1. OME of short duration - recommend against PE tube with single episode of OME less than 3 months duration.
2. Hearing Test - obtain an age appropriate hearing test for OME greater than 3 months or prior to tube insertion.
3. Do offer tubes for OME greater than 3 months and documented hearing difficulty.
4. Do reevaluate in 3-6 months for COME if parents opt Not to place tubes.
5. Hold off on placing tubes for rec AOM if normal ENT exam and Audio. (exception ie unacceptable antibiotic burden)
6. Do offer tubes for rec AOM and MEE at time of ENT visit.
7. Consider tubes if determined to be at increased risk for speech, language or learning problems from otitis media. Risk factors include: Permanent hearing loss, confirmed speech delay, autism, syndromes, uncorrectable visual impairment, cleft palate, developmental delay
8. Offer tubes earlier than 3 months for at risk children depending.
9. Educate caregivers about tube duration, follow up schedule and complications.
10. Clinician should prescribe topical antibiotic eardrops only, without oral antibiotics for uncomplicated acute otitis media.
11. Prophylactic water precautions not needed for swimming unless in lake. Continue water precautions for child with otorrhea or hx of recurrent otorrhea.

About PE tubes

Goal of surgery is to place a tiny tube in the eardrum to improve Eustachian tube function and reduce fluid buildup.

Surgery takes about 10-20 minutes under general anesthesia.

Hearing loss from fluid improves immediately.

About 1 in 4 children get an ear infection (drainage) that is treated with ear drops.

Use only eardrops that are safe referred TM perforations. Ofloxacin, ofloxacin ophthalmic drops, Ciprodex.

A plugged PE tube can be treated with hydrogen peroxide.

Most tubes fall out by 12 months of being placed. About 2-3 children in 100 while have a residual perforation and may need surgery later.

Regular ENT follow up encouraged. Persistent drainage, concern for granulation tissue.
Clinical Practice Guideline - Otitis Media with Effusion (Rosenfeld et al., 2016)

Summary of Guideline Action Statements

1. The clinician should perform pneumatic otoscopy to assess for OME in a child with otalgia, hearing loss or both.
2. Clinician should obtain tympanometry with suspected OME after performing her attempting pneumatic otoscopy.
3. For failed newborn hearing screening, clinician should document counseling of parents of infant’s regarding importance of follow-up to ensure hearing is normal when OME resolves.
5. Healthy children do Not need screening for OME
6. Clinicians should educate families about natural hx of OME, follow up and possible sequela.
7. Watchful waiting for us to 3 months is strongly recommended for child with OME and not at risk.
8. Clinicians should Not prescribe systemic antibiotics or intranasal steroids for treating OME.
9. Clinician should Not recommend antihistamines and or decongestants for treating OME.
10. Obtain a hearing test if OME persists > 3 months or sooner in at-risk child.
11. Clinicians should reevaluate child with OME at 3- 6 month intervals until OME resolves, hearing loss is identified or show abnormalities of middle ear suspected.
12. Surgery for OME in child < 4 yrs., should Not include adenoidectomy unless a clear indication other than OME. (Nasal obstruction, chronic adenoiditis).
13. Surgery for OME in child > 4 yrs. should include PE tubes and adenoidectomy.

About Adenoids

Adenoids which are present at birth usually shrink by age 7.

Adenoids can become enlarged with allergies and infection and may shrink back to normal size.

Chronically enlarged adenoids can cause nasal congestion, ETD, trouble breathing through the nose, causing frequent open mouth breathing, cavities, malocclusion and sore throats. Adenoiditis is usually viral but frequent URIs and or sinusitis may be an indication for adenoidectomy.
Clinical Practice Guideline - Tonsillectomy in Children (Baugh et al., 2011)

Summary of Guideline Action Statements

1. Recommend watchful waiting if there have been fewer than 7 episodes in past year, fewer than 5 times for 2 years or 3 times in the past 3 years.

2. May recommend tonsillectomy if criteria met and the following: Temperature greater than 38.3, cervical adenopathy, tonsillar exudate or positive GABHS.

3. If criteria are not met evaluate for multiple antibiotic allergies/intolerance, history of peritonsillar abscess, or PFAPA (periodic fever, aphthous pharyngitis, and adenitis).

4. Clinicians should evaluate children with sleep disordered breathing (SDB) and tonsil hypertrophy about comorbid conditions which may improve after tonsillectomy, including growth retardation, poor school performance, enuresis and behavioral problems.

5. Clinician’s should counsel caregivers about tonsillectomy as a means to improve health in children with abnormal sleep study who also have enlarged tonsils and SDB.

6. Clinicians should explain that SDB may persist or recur after tonsillectomy and may require further management.

7. Children should receive a single dose of IV dexamethasone while undergoing tonsillectomy.

8. Children should not routinely receive perioperative antibiotics undergoing tonsillectomy

9. Clinician should advocate for pain management after tonsillectomy and educate about the importance of managing and reassessing pain

10. ENT Surgeons should determine their rate of primary and secondary post tonsillectomy hemorrhage at least annually
Clinical practice guideline - Polysomnography (PSG) for Sleep Disordered Breathing Prior to Tonsillectomy in Children (Roland et al., 2011)

Summary of guideline action statements

1. Prior to tonsillectomy, clinician should refer children with SDB for PSG if they have any of the following: Obesity, Down syndrome, craniofacial abnormalities, neuromuscular disorders, sickle cell disease or mucopolysaccharidosis.

2. Clinician should advocate for PSG for children without any of the above comorbidities when need for surgery is uncertain or there is discordance between tonsillar size on physical exam and the reported severity of SDB.

3. The anesthesiologist should have the results of the PSG prior to induction of anesthesia for tonsillectomy in a child with SDB.

4. Clinician should admit children with OSA for inpatient, overnight monitoring after tonsillectomy if under age 3 or have severe OSA, (apnea–hypopnea index of 10 or more obstructive events per hour, O2 sat less than 80%, or both).

5. In children for whom PSG is indicated prior to tonsillectomy, clinician should obtain a laboratory based PSG when available.

How to Prepare Caregivers and Child for a Sleep Study

What is Does a Sleep Study measure?
Clinical Practice Guideline - Diagnosis and Management of Acute Bacterial Sinusitis in Children aged 1-18 years. (Wald at al., 2013)

Summary of guideline action statements

1. Clinician should make a presumptive diagnosis of acute bacterial sinusitis when a child with an acute URI has the following: Persistent illness, nasal discharge or daytime cough or both lasting more than 10 days without improvement;

   OR worsening course, i.e. worsening or new onset of nasal discharge, daytime cough or fever after initial improvement:

   OR severe onset, i.e. concurrent fever > 102.2 and purulent nasal discharge for at least 3 consecutive days

2A. Clinicians should not obtain imaging studies (plain films, contrast-enhanced CT, MRI or ultrasound) to distinguish acute bacterial sinusitis from viral URI.

   Clinicians should obtain a contrast-enhanced CT of the paranasal sinuses and/or n MRI with contrast whenever child is suspected of having orbital or CNS complications of acute bacterial sinusitis.

3. Severe onset and worsening course” acute bacterial sinusitis. The clinician should prescribe antibiotic therapy for acute bacterial sinusitis in children with severe onset or worsening course (signs, sx or both).

3B. “Persistent illness.” The clinician should either prescribe antibiotic therapy OR offer additional outpatient observation for 3 days to children with persistent illness (nasal discharge or any quality or cough for at least 10 days without evidence of improvement).

4. Clinician should prescribe amoxicillin with or without clavulanate as first line treatment when a decision has been made to initiate antibiotic treatment of acute bacterial sinusitis.

5. Clinician should reassess initial management if there is either a caregiver report of worsening symptoms or appearance of new signs or symptoms OR failure to improve within 72 hours of initial management.

   If the diagnosis of ABS is confirmed a child with worsening symptoms or failure to improve and 72 hours, then antibiotic may be changed OR initiate antibiotic if child initially managed with observation