

Clinical practice guideline: diagnosis and management of acute otitis media

[Health & Medicine](#), [Nursing](#)



Acute Otitis Media A. Review the sources of evidence listed above and do the following: A1. Type of source of evidence The first article (excerpt) ' Ear nose and throat' is a filtered source of evidence. The reason it qualifies as a filtered source is that there is pre-decided aspect involved in the study. Using keywords to search it makes the evidence unfiltered, however this is a chapter with a title ' Ear nose and throat' from the book Current Pediatric Diagnosis and Treatment. The source is a database (published book), which pre-decides what the reader will see. As far as the question of filtering the evidence is concerned, the excerpt does offer filtered evidence. Based on the same principle of keyword and content vagueness, the other two articles, ' Causative pathogens, antibiotic resistance and therapeutic considerations in acute otitis media', and ' Treatment of acute otitis media in an era of increasing microbial resistance', both published in Pediatric Infectious Disease Journal are unfiltered. The article ' Diagnosis and Management of Acute Otitis Media' published in the American Academy of Pediatrics And American Academy of Family Physicians and the article Diagnosis and Management of Acute Otitis Media, published in Pediatrics is filtered. Lastly the ' parents' interview' is a primary source. A2. Appropriate for this nursing practice situation The article ' Diagnosis and Management of Acute Otitis Media' published in the American Academy of Pediatrics and American Academy of Family Physicians qualifies as appropriate for the nursing practice situation. The abstract of the article clearly states that it is an " evidence-based" clinical practice guideline that gives recommendations to primary care clinicians regarding the treatment of AOM children between the ages of 2months to 12 year olds for the managing (which is what the nursing

discussion is about). The diagnosis, treatment and precautions offered are appropriate for nursing practice. For instance, the first excerpt ' Ear nose and throat', mentions Otitis Externa, and tells the patient if in the condition is in the acute phase; they should avoid swimming, moreover, a cotton ear plug won't be sufficient and may spread the infection further (Kelly, Freedman & Johnson, 2007). The second article ' Causative pathogens, antibiotic resistance and therapeutic considerations in acute otitis media' offers information on ' isolated pathogens' (Block, 1997) in patients, which is helpful in understanding AOM however probably not appropriate under the situation. The third ' Treatment of acute otitis media in an era of increasing microbial resistance' discusses more advanced treatment (Streptococcus pneumoniae) for children with AOM (McCracken, 1998), again not appropriate under current situation. Parent interviews showed that parents were comfortable if there was enough evidence to change the policy.

Majority of them said that they wanted the best for their children and nurses and doctors know best what to do. A few of them did object, especially those that had some previous ' accidents' with antibiotics. Parent interviews are appropriate in the discussion of changing the clinic policy for it is with the consent of the parents their children will be treated. A3. Classification of each source of evidence The first article (excerpt) ' Ear nose and throat' from the book Current Pediatric Diagnosis and Treatment is classified as filtered, an evidence summary because it is an excerpt from a book. Sources of the knowledge in that chapter are other books (it is not explicitly written that it was a primary research). The second article ' Causative pathogens, antibiotic resistance and therapeutic considerations in acute otitis media' from the

medical journal The Pediatric Infectious Disease Journal, is an unfiltered source of evidence. The reason for this conclusion is that nothing is pre-decided here, it is proceeding from a symposium and is an 'evidence summary'. There are key words vividly given at the start of the journal article. The third article (a journal article) is also an unfiltered source. The article titled 'Treatment of acute otitis media in an era of increasing microbial resistance' is also published in the journal The Pediatric Infectious Disease Journal. This article is a supplement to Current Assessment of Diagnosis and Management of Otitis Media, therefore an evidence summary. The fourth article, 'Diagnosis and Management of Acute Otitis Media', published in the journal Pediatrics is a published article, also available from website. It qualifies as a filtered source database. The abstract makes it quite clear what the reader should expect from this. This article is an "evidence-based" clinical practice guideline. The fifth source is 'parent interviews', which is a primary research evidence.

B. Appropriateness of Clinical Practice Guideline Review

The clinical practice guideline from the American Academy of Pediatrics And American Academy of Family Physicians journal proposes well researched recommendations. For instance, in order to diagnose AOM, the first thing a clinician should do is to confirm the history of acute onset. Next, identifying the signs of MEE, and evaluation for testing the presence of symptoms of middle-ear inflammation would be very safe and a tested procedure. This procedure is appropriate as it includes 136 references in concluding the recommendations. For instance, besides diagnosing AOM, the management of AOM must comprise a pain assessment procedure. The procedure is appropriate because ignoring pain

can be very damaging for the patient as well as the condition he/she is in. If pain exists, the clinician can work toward alleviating or reducing pain. Instead of delving into the applications of the findings, it would be more helpful to understand the construction of this guideline, this way it will be much easier to categorize it as appropriate or inappropriate. The American Academy of Pediatrics and American Academy of Family Physicians summoned a board of primary care physicians and talented specialists in the fields of infectious disease, otolaryngology and epidemiology. The subcommittee worked with the Agency for Healthcare Research and Quality and the Southern California Evidence-Based Practice Center for reviewing the evidence-based AOM literature. The article addresses the association of age less than 2 years with increased risk of watchful waiting fails and the fear of grave infection in children less than 6 months of age. These aspects tremendously influence “ immediate antibacterial therapy” decision. Despite being a broad ranged report, the evidence is more focused toward the appropriate diagnosis and initial treatment of a child suffering from AOM. The “ observation option” (watchful waiting) for AOM refers to delaying antibacterial treatment in selected children for a time period of 48 to 72 hours and restraining treatment to only management, for a symptomatic relief. The decision to watchful waiting or treating with antibiotics depends on the child’s age, diagnostic certainty, and the severity of illness. C.

Application of findings The application findings boil down to three categories;

A) children less than 6 months with certain/uncertain AOM diagnosis need antibacterial treatment. B) Children between the ages of 6months-2 year olds need antibacterial therapy in certain diagnosis. In uncertain diagnosis

and illness is non-severe, observation option can be opted for. If illness is severe, antibacterial treatment is a must. C) For children over 2 years old, with an uncertain diagnosis, observation option can be exercised. In case there is a certain diagnosis and the illness is non-severe, observation option (watch and wait) can be exercised. However if the illness is severe, antibacterial therapy should be opted (please refer to page 1454 of the article 'Diagnosis and Management of Acute Otitis Media' for a complete discussion regarding temperature changes for watchful waiting). There are certain options while treating in a preliminary care, observation without using antibacterial agents in a child with simple case of AOM is a choice for 'some' children. These children must be selected based on; age, diagnostic certainty, illness severity, and guarantee of a follow-up. In case a judgment is made to treat the child with an antibacterial agent, the clinician should recommend amoxicillin. This is the general case and works effectively on most children (based on evidence). When amoxicillin is prescribed, the dose should not exceed 80-90mg/kg per day. D. Ethical issues in research For the purpose of this evidence based research, the children tested were not from a random sample, they were carefully selected. These children did not have any severe AOM illnesses. This raises no ethical issues whatsoever.

Otherwise ethical issue of 'experimenting' with severely sick patients could arise. D1. (Ethical) Issues for vulnerable populations Voluntary participation, informed consent, risk of harm, confidentiality and anonymity are some of the major issues for vulnerable populations. All of these matters were kept in focus for the research. The research is an extraction, discussion and analysis of many previous research studies, for instance, the placebo-controlled trials

of AOM over the past 30 years have been used, and they show that majority of the children do well without anti-bacterial therapy, thus raising no ethical issues. Works Cited American Academy of Pediatrics and American Academy of Family Physicians. (2004). Clinical practice guideline: Diagnosis and management of acute otitis media. Retrieved August 27, 2012, from <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/5/1451>

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