

**TABLE 4** Recommendations for Initial Management for Uncomplicated AOM<sup>a</sup>

Age	Otorrhea With AOM <sup>a</sup>	Unilateral or Bilateral AOM <sup>a</sup> With Severe Symptoms <sup>b</sup>	Bilateral AOM <sup>a</sup> Without Otorrhea	Unilateral AOM <sup>a</sup> Without Otorrhea
6 mo to 2 y	Antibiotic therapy	Antibiotic therapy	Antibiotic therapy	Antibiotic therapy or additional observation
≥2 y	Antibiotic therapy	Antibiotic therapy	Antibiotic therapy or additional observation	Antibiotic therapy or additional observation <sup>c</sup>

<sup>a</sup> Applies only to children with well-documented AOM with high certainty of diagnosis (see Diagnosis section).

<sup>b</sup> A toxic-appearing child, persistent otalgia more than 48 h, temperature  $\geq 39^{\circ}\text{C}$  ( $102.2^{\circ}\text{F}$ ) in the past 48 h, or if there is uncertain access to follow-up after the visit.

<sup>c</sup> This plan of initial management provides an opportunity for shared decision-making with the child's family for those categories appropriate for additional observation. If observation is offered, a mechanism must be in place to ensure follow-up and begin antibiotics if the child worsens or fails to improve within 48 to 72 h of AOM onset.

**TABLE 5** Recommended Antibiotics for (Initial or Delayed) Treatment and for Patients Who Have Failed Initial Antibiotic Treatment

Initial Immediate or Delayed Antibiotic Treatment		Antibiotic Treatment After 48–72 h of Failure of Initial Antibiotic Treatment	
Recommended First-line Treatment	Alternative Treatment (if Penicillin Allergy)	Recommended First-line Treatment	Alternative Treatment
Amoxicillin (80–90 mg/kg per day in 2 divided doses)	Cefdinir (14 mg/kg per day in 1 or 2 doses)	Amoxicillin-clavulanate <sup>a</sup> (90 mg/kg per day of amoxicillin, with 6.4 mg/kg per day of clavulanate in 2 divided doses)	Ceftriaxone, 3 d Clindamycin (30–40 mg/kg per day in 3 divided doses), with or without third-generation cephalosporin Failure of second antibiotic
or	Cefuroxime (30 mg/kg per day in 2 divided doses)	or	
Amoxicillin-clavulanate <sup>a</sup> (90 mg/kg per day of amoxicillin, with 6.4 mg/kg per day of clavulanate [amoxicillin to clavulanate ratio, 14:1] in 2 divided doses)	Cefpodoxime (10 mg/kg per day in 2 divided doses)	Ceftriaxone (50 mg IM or IV for 3 d)	Clindamycin (30–40 mg/kg per day in 3 divided doses) plus third-generation cephalosporin Tympanocentesis <sup>b</sup> Consult specialist <sup>b</sup>
	Ceftriaxone (50 mg IM or IV per day for 1 or 3 d)		

IM, intramuscular; IV, intravenous.

<sup>a</sup> May be considered in patients who have received amoxicillin in the previous 30 d or who have the otitis-conjunctivitis syndrome.

<sup>b</sup> Perform tympanocentesis/drainage if skilled in the procedure, or seek a consultation from an otolaryngologist for tympanocentesis/drainage. If the tympanocentesis reveals multidrug-resistant bacteria, seek an infectious disease specialist consultation.

<sup>c</sup> Cefdinir, cefuroxime, cefpodoxime, and ceftriaxone are highly unlikely to be associated with cross-reactivity with penicillin allergy on the basis of their distinct chemical structures. See text for more information.

### Duration of Therapy

The optimal duration of therapy for patients with AOM is uncertain; the usual 10-day course of therapy was derived from the duration of treatment of streptococcal pharyngotonsillitis. Several studies favor standard 10-day therapy over shorter courses for children younger than 2 years.<sup>162,190–194</sup> Thus, for children younger than 2 years and children with severe symptoms, a standard 10-day course is recommended. A 7-day course of oral antibiotic appears to be equally effective in children 2 to 5 years of age with mild or moderate AOM. For children 6 years and older with mild to moderate

symptoms, a 5- to 7-day course is adequate treatment.