LETTERS

Watchful Waiting for AOM?

I read the ID Consult on acute otitis media (AOM) article ("Observation Option for AOM: A Second Look," April 2011, p. 12) with great interest. I respectfully but vigorously disagree with Dr. Michael E. Pichichero's statement, "I don't see how any clinician can withhold antibiotic treatment in good conscience." I am a general practice pediatrician. I own a Welch Allyn MacroView and feel that I usually get an excellent view of the tympanic membrane. I have seen many clearly bulging red tympanic membranes with effusion, sudden onset of fever, and crying, that resolved in 8 hours or less (or at least the erythema, fever, and fussiness did). I am not against treating some severe AOM, but would continue to do so selectively. I also believe it is important to include the parents in this decision. The slightly faster resolution of AOM, even though statistically significant, would not convince me as a patient, a parent, or a physician that I would want to treat all AOM with Augmentin (amoxicillin clavulanate). I would certainly want to treat the child's pain and discomfort (just as we do for any other painful childhood condition) with ibuprofen, A/B Otic, or other means. But even treating the most strictly defined AOM with one of the most powerful oral broad spectrum antibiotics we have at our disposal, gives only a few percentage points difference in improvement over the placebo (35% vs. 28% at day 2 and 80% vs. 74% at day 7). In the other study cited, 75% of AOM resolved on placebo by day 3 vs. 84% with amoxicillin clavulanate.

I see so many side effects from amoxicillin clavulanate – from immediate abdominal symptoms to later yeast infections/thrush. Some studies even suggest that the more antibiotic courses a patient has, the more long-term ill effects result. The medicine is also very expensive (and not covered by Medicaid), and society pays through increased antibiotic resistance.

If I were a parent of a child with AOM, I would wait to see if my child could avoid antibiotics while I treated his or her pain, which is what most parents in my practice do. There may be a day or two more of ibuprofen for those who wait, but that is balanced out by reduced abdominal pain, vomiting, diarrhea, or hives from Augmentin. I completely disagree that immediate treatment with an antibiotic is "a moral imperative." I think it mistreats the great majority of families.

Katya Gerwein, M.D.
Berkeley, Calif.

I read Dr. Pichichero's article on acute otitis media (AOM) with great interest, and I agree wholeheartedly with his conclusions. As he pointed out in the article, the use of antibiotics for true AOM is beneficial; the problem is we often have difficulty in reaching the correct diagnosis. The same logic applies to many of the most common conditions that present themselves to pediatricians. Pharyngitis is routinely mishandled, with treatment often given despite a negative rapid strep test, and intramuscular injections of ceftriaxone are often administered when a child's white blood cell count is greater than 15,000/mm^3 as a knee-jerk reflex despite the currently very low risk of occult bacteremia in low-risk children. It is this misuse of antibiotics we should try to curb, not the appropriate use of antibiotics in the setting of a clear case of AOM.

Peter Palmieri, M.D.
Dallas

While I appreciated Dr. Pichichero's thoughts on the two studies of antibiotic treatment for young children with acute otitis media (AOM), I disagree for several reasons with his characterization that these studies undermine the endorsement of watchful waiting for some cases of AOM by the American Academy of Pediatrics.

First of all, the AAP guideline endorses watchful waiting for children between 6 months and 2 years of age only if they have both mild symptoms *and* an uncertain diagnosis. Both of the studies under discussion specifically excluded children with an uncertain diagnosis; thus, their results simply don't apply to the children under age 2 for whom watchful waiting is endorsed by the AAP. Second, while both recent studies showed benefits of antibiotic treatment, the results were hardly a slam dunk for antibiotics! The benefits were fairly modest, the number of children experiencing antibiotic-related adverse effects was substantial, and neither study was designed to determine the overall public health effect of treating all cases of AOM with a broad-spectrum antibiotic (remember, both studies used amoxicillin clavulanate). Unless we are willing to give every child with AOM amoxicillin clavulanate or a similar broad-spectrum antibiotic as a first-line therapy, we can hardly expect to see the benefits reported in the studies. Is Dr. Pichichero willing to make such a recommendation?

Finally, watchful waiting is not synonymous with no treatment. Watchful waiting implies a shared decision between provider and family for symptomatic treatment of pain and close follow-up, with antibiotics readily available if the child does not improve promptly. The AAP guideline goes to great lengths to emphasize appropriate analgesia, and antibiotics certainly do not provide immediate pain control. Parents and providers who choose watchful waiting are accepting one risk (the risk of the child not getting better or even getting worse) for another (the risks to the child, family, and community of antibiotic exposure). It's presumptuous to say that parents can't be part of this decision for their children when there is reasonable equipoise in the risk-benefit equation.

As to Dr. Pichichero's plea for better training of our pediatricians and family physicians to diagnose AOM appropriately, more power to him!

Louis Vernacchio, M.D.
Boston

Dr. Pichichero replies:

I appreciate the interest that my column has raised on the diagnosis and management of ear infections in children. All three letters emphasize the need for analyzing trade-offs in the management arena, but all three appear to endorse better training to achieve better diagnosis. I would reiterate that based on prior work by me and others in the field, it is not unreasonable to suggest that 50% of AOM is overdiagnosed. If the child does not have the bacterial infection, then they surely will get better with watchful waiting or analgesics alone. As far as management, indeed in my clinical practice and in a research study we are currently conducting with National Institutes of Health sponsorship, we treat all children with AOM, confirmed by tympanocentesis, with amoxicillin clavulanate (high dose) as first-line therapy. Since the introduction of Prevnar 7, and now even more so with the introduction of Prevnar 13, I predict that the otopathogen mix has shifted and will continue to shift toward beta-lactamase-producing *Haemophilus influenzae* and *Moraxella catarrhalis*. Amoxicllin is a placebo against these organisms.

LETTERS

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LETTERS FROM MAINE

Ticked Off

I recently surveyed my partners and learned that over the last 5 years, they have lost only two patients to "chronic Lyme disease." Considering that we've got droves of ticks, we should be proud of that statistic – but when I say "lost," I'm not referring to mortality. Although we have seen plenty of Lyme disease and one young man ended up in the ICU with heart block, we haven't had any deaths that could be attributed to the disease. The losses I am referring to are patients who found their ways to other physicians and were diagnosed with chronic Lyme disease.

WILLIAM G. WILKOFF, M.D.

I know I may be stepping into a hornet's nest with this observation, but I am not convinced that chronic Lyme disease exists as a diagnosable clinical entity. But I haven't read any credible peer-reviewed articles that make me abandon my adherence to the Centers for Disease Control and Prevention's recommendation against long-term antibiotics when Lyme disease is only suspected. We're dealing with an illness that may or may not have a rash and a collection of vague symptoms including joint swelling, low-grade fever, fatigue, and myalgias, so a diagnosis based on examination alone can be difficult. Compound this with the lack of a black-and-white laboratory test for a patient with early symptoms, and it's a disease that can at times seem to be shrouded in a haze of mystery. Fear often stalks where mystery is deepest. Fifteen years ago, when Lyme disease was all the rage in Connecticut and coastal Massachusetts, I was afraid that we had been missing it. We had all the ingredients. Maybe we were calling it something else. But we didn't seem to be having an unusual number of undiagnosed problems. However, once the disease really showed up, it was clear we hadn't been missing any cases. The presentations were protean but there was always something concrete that set us on the right track. The rash (primary or secondary), a single joint, a Bell's palsy ... something. Treatment was effective.

What hasn't been easy is that there continue to be, and always will be, patients with vague symptoms of fatigue, headache, general body aches, and mild depression who never seem to rest comfortably in a diagnostic niche. They have none of the specific signs or symptoms of Lyme disease, nor does their lab work suggest it as a diagnosis, nor does any other diagnosis pop into mind.

Unfortunately, these patients may find physicians who not only feel that chronic Lyme disease exists (I grudgingly agree that a post–Lyme disease symptom complex might exist) but also believe that it should be treated with antibiotics. These practitioners also must believe that it is a very common condition, because an uncomfortably high percentage of their patients receive the diagnosis.

Staying engaged with these enigmatic patients can be difficult. They want a diagnosis as much as we want to provide one, but mostly they want to get better. It is difficult to continue to appear confident with the attitude that no diagnosis is a safer alternative to the wrong diagnosis. Heavy doses of reassurance and frequent brainstorming visits in hopes of finding an answer can weaken over time. It's not surprising that many families grow impatient with our efforts and seek other opinions. And it's only natural to feel devalued when this happens to us. The challenge is to channel this emotion into introspection, and to search for a better way to manage similar situations when they occur. ■

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