Letter to the Editor

In Reference to What is the Role of Tympanostomy Tubes in the Treatment of Recurrent Acute Otitis Media?

As regards Casselbrant et al. 1992; Clarification and Current Postscript:

We assume that Whittemore’s report1 was referring to our trial2 when he concluded that the “level of evidence favoring TT placement is 1b given that there is an individual, randomized, controlled trial.” However, we want to clarify certain aspects of our trial since there has been some confusion related to outcomes. Also we want to provide our current recommendations as our report is now over 20 years old.

Whittemore’s statement, citing Hellström et al.,3 that in our trial “No significant difference in rate of AOM was found between TT placement and placebo,” needs clarification. The confusion may come from our statement that “The average rate of new episodes per child year of either acute otitis media or otorrhea was—amoxicillin vs. placebo, \( P < 0.001; \) tubes vs. placebo, \( P = 0.25. \)” In that trial we elected to include any occurrence of otorrhea as an AOM episode, but these subjects were examined routinely 1 × /month, as well as for sick visits, and many of the episodes of post-TT otorrhea were asymptomatic and not apparent to the parents, that is, occult. Indeed, we stated “Tympanostomy tube insertion may be followed by episodes of otorrhea, but these are usually otherwise asymptomatic and less troublesome than episodes of acute otitis media in children with intact eardrums.” These episodes of otorrhea were of short duration when compared with episodes of AOM in the ears without TT—which was confirmed by the significantly reduced average proportion of time with otitis media of any type in children receiving TT versus those receiving placebo (\( P < 0.001 \)). Our rate of otorrhea was higher than most published in the literature.4

Thus, TT and prophylaxis were each significantly superior to placebo. In 1992, we concluded prophylaxis was the preferred first measure to prevent recurrent AOM (rAOM). But our trial was conducted before the recognition that long-term, low-dose amoxicillin prophylaxis is associated with the emergence of antibiotic-resistant otic pathogens. Currently, prophylaxis is not routinely recommended; accordingly, today children in whom rAOM has reached extreme levels of frequency and/or severity should receive TT placement and not prophylaxis. However, prophylaxis with an appropriate antimicrobial agent may be an option when a child is a poor candidate for anesthesia, that is, risks outweigh benefits, or when TT tubes are not elected following a shared decision-making discussion with the parents weighing TT placement against prophylaxis.

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