

**Primary Care Management of Otitis Externa**

Full NICE guidance:

<https://cks.nice.org.uk/otitis-externa#!topicsummary>

**Summary of guidance:**

In all cases, ask about hearing loss and if present, record Weber and Rinne test findings.

**Treatment of acute diffuse otitis externa**

Prescribe or recommend an analgesic for symptomatic relief.

Treat inflammation using a topical ear preparation for 7 days.

Mild cases - (itching/ pruritis , no pus/swelling) consider prescribing topical acetic acid 2% spray.

Moderate - Severe cases (pain, deafness, and/or discharge), or if treatment with topical acetic acid is not effective, consider prescribing a topical antibiotic with or without a topical corticosteroid. Tragal massage increases efficacy.

eg. Genticin/ gentisone HC, Otomise,

(If no improvement after 1/52, the consider taking swabs to check sensitivities)

Refer urgently, on the day - immunocompromised patients (including DM), those with lower motor neurone palsy or those with severe pain

If there is sufficient earwax or debris to obstruct topical medication, consider ENT referral for suction clearance

If there is extensive swelling of the auditory canal or failure to respond to topical treatment, consider Rapid access ENT referral for insertion of an ear wick

Only consider adding an [oral antibiotic](https://cks.nice.org.uk/otitis-externa#!scenarioclarification/-502147) for people with severe infection/ cellulitis.

Flucloxacillin/ Erythromycin/ clarithromycin

Review after 3/7 and if no better, consider admission for IV antibiotics

Consider fungal infection if no response to antibiotics.

Canestan ear drops/ locorten vioform

**Treatment of acute localized otitis externa (boil or furuncle present in external auditory canal)**

Prescribe or recommend analgesia and warm compresses

Only consider an oral antibiotic for people with severe infection, or at high risk of severe infection, for example if:

* Furunculosis or cellulitis spreads beyond the ear canal to the pinna, neck, or face.
* There are systemic signs of infection, such as fever.
* The person has a condition (for example poorly-controlled diabetes or compromised immunity) that is associated with increased risk of severe infection.

1st line : Flucloxacillin/ erythromycin/ clarithromycin.

Review after 3/7 and if no improvement, consider referral for IV antibiotics

**Chronic diffuse otitis externa**

Reinforce [self-care advice](https://cks.nice.org.uk/otitis-externa#!scenariorecommendation:12), such as avoiding damage to the external ear canal and keeping the ears clean and dry.

Consider taking ear swabs if fails to respond to treatment

**If fungal infection is suspected** **(signs of fungal growth in ear canal):**

* Prescribe a topical antifungal preparation.
* For mild-to-moderate and uncomplicated fungal infections, consider one of the following options:
  + A topical antifungal: clotrimazole 1% solution.
  + Acetic acid 2% spray (unlicensed use).
  + A topical preparation containing clioquinol and a corticosteroid for example Locorten–Vioform®.

Seek specialist advice if there is inadequate response.

**If the cause seems to be seborrhoeic dermatitis:**

* Treat topically with an antifungal–corticosteroid combination or trial of diprosalic scalp lotion

**If no cause is evident:**

* Prescribe a 7-day course of a topical preparation containing only a corticosteroid *without antibiotic*, or trial of diprosalic scalp lotion. Consider co-prescribing an acetic acid spray.
* If there is an adequate response:

Continue the corticosteroid treatment. However, reduce the potency of the corticosteroid and/or the frequency of application to the minimum required to maintain control

* If treatment cannot be withdrawn after 2 or 3 months, seek specialist advice.
* If the response is inadequate, consider a trial of a topical antifungal preparation.