Otitis Externa

Organisms (usually present as secondary colonisers)

- *Pseudomonas aeruginosa*
- *Staphylococcus aureus*
- Group A streptococcus (especially if inflamed)
- *Aspergillus* spp. and other fungi

Treatment

- If severe or unable to get drops into the ear canal, then refer to ENT for aural toilet.
- Acetic acid 2% spray (EarCalm Spray®) is as effective as topical antibiotic in *mild otitis externa* for the first 7 days.
- In more severe cases, a topical antibiotic plus steroid ear drops may be considered as first line.
- Topical application of a ribbon gauze dressing soaked with corticosteroid ear drops may be beneficial where swelling is to the extent that drops will not readily penetrate
- Aminoglycoside ear drops are potentially toxic and should not be given in the presence of a perforation with a discharge for more than 10 days without being reassessed. An underlying perforation is likely, and should be excluded if there is a mucoid discharge. In many cases of otitis externa there is no underlying perforation and ear drops can be given for longer. If there is a history of recurrent discharge an underlying cholesteatoma should be excluded
- Diabetic and immunocompromised patients are particularly susceptible to aggressive destruction of cartilage caused by *Pseudomonas aeruginosa* (“Malignant Otitis Externa”). If suspected, the patient should be referred urgently to an ENT specialist.
- Otitis externa not responding to treatment and with persistent pain after 5-7 days should be referred urgently to an ENT specialist.

Systemic antibiotics are only indicated when there is evidence of spreading cellulitis.

Choice of antibiotics depends on likely organisms:

- *Staphylococcus aureus* (folliculitis or pustular lesions) or Group A Streptococcus – flucloxacillin
- *Pseudomonas aeruginosa* – use topical applications as suggested above. If severe infection, discuss with an ENT specialist.
- *Candida* – 1% clotrimazole ear drops.
- *Aspergillus* – Discuss treatment with an ENT specialist
### Drug Antimicrobial Prescribing Guidelines for Primary Care

**Updated January 2019. Next review: January 2022.**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose (adult)</th>
<th>Duration of Treatment</th>
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</thead>
<tbody>
<tr>
<td><strong>First line:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetic acid 2% spray</td>
<td>1 spray at least TDS (maximum 2-3 hourly)</td>
<td>7 days</td>
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<tr>
<td><strong>Second line choices</strong></td>
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<td></td>
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<tr>
<td>Gentamicin with hydrocortionse® drops (not if perforation)</td>
<td>2-4 drops QDS</td>
<td>7 days</td>
</tr>
<tr>
<td>Locorten-Vioform® drops</td>
<td>2-3 drops BD</td>
<td>7 days</td>
</tr>
<tr>
<td>Otomize® spray</td>
<td>1 spray TDS</td>
<td>7 days</td>
</tr>
<tr>
<td>Sofradex® drops</td>
<td>2-3 drops TDS – QDS</td>
<td>7 days</td>
</tr>
<tr>
<td>Clotrimazole 1% ear drops</td>
<td>3 drops BD-TDS</td>
<td>For at least 14 days after resolution of symptoms</td>
</tr>
<tr>
<td>Ciprofloxacin Cetraxal® UDV drops 0.2%</td>
<td>1 UDV BD</td>
<td>7 days</td>
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</table>

**Only if spreading cellulitis:**

- **Flucloxacillin**
  - 500mg QDS
  - 5 days

**In penicillin allergy use:**

- **Clarithromycin**
  - 500 mg BD
  - 5 days

- **Or Doxycycline**
  - 200mg first day then 100mg OD
  - 5 days