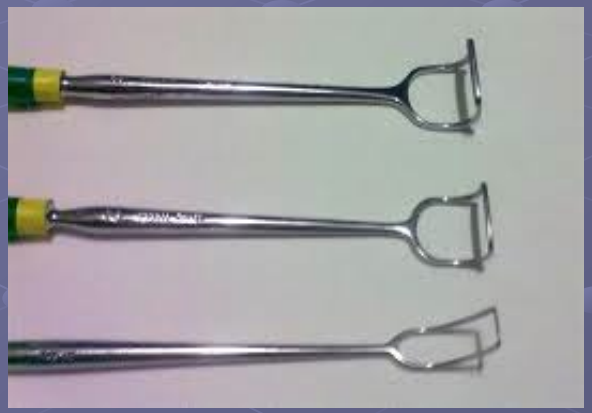
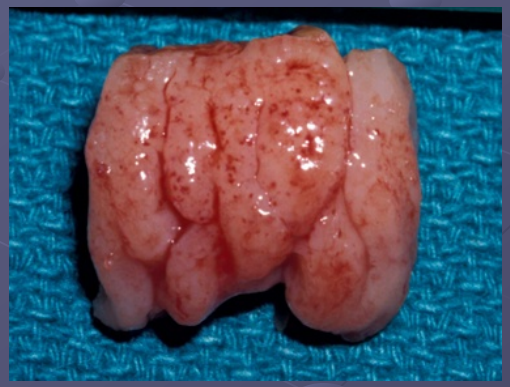
Adenotomia

- L’adenotomia crea una superficie liscia, priva di cripte meno favorevole alla colonizzazione batterica





American Medical Association (2015)

Adenoidectomy is considered **medically necessary** for individuals *under the age of 18 years old* when any of the following conditions are met:

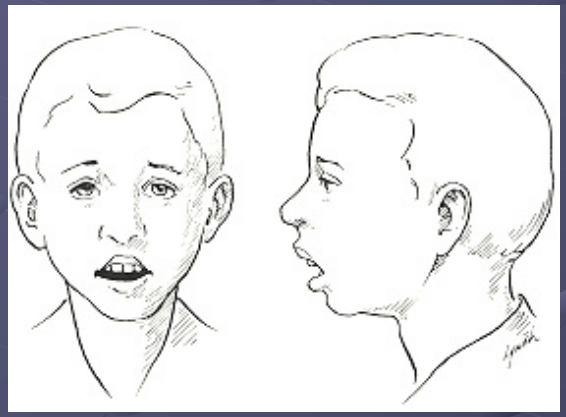
- Chronic (greater than or equal to 12 weeks in duration) adenoiditis with rhinorrhea, despite a minimum of 3 weeks of appropriate antibiotic treatment; **or**
- Chronic rhinosinusitis (idem), **or**
- ≥4 episodes of recurrent adenoiditis with purulent rhinorrhea in the prior 12 months in a child <12 years of age. At least one episode should be documented by intranasal examination or diagnostic imaging; **or**

American Medical Association (2015)

- Adenoid hypertrophy and chronic OME in children >4 years of age with a history of prior failed tube tympanostomy and no evidence of nasal obstruction, recurrent sinusitis, or chronic sinusitis, when done in conjunction with either

a) myringotomy or

b) tube tympanostomy



American Medical Association (2015)

- Adenoid hypertrophy documented by imaging, nasopharyngoscopy or endoscopy with symptomatic airway obstruction as demonstrated by any of the following:

a. In children with sleep-disordered breathing (SDB) with documentation of symptoms >3 months in duration regular episodes of nocturnal choking, gasping, apnea, or breath holding, snoring, mouth breathing, and pauses in breathing;

or

American Medical Association (2015)

- Adenoid hypertrophy documented by imaging, nasopharyngoscopy or endoscopy with symptomatic airway obstruction as demonstrated by any of the following:

c. A condition related to SDB (including but not limited to growth retardation, poor school performance, enuresis, and behavioral problems) that is likely to improve after adenoidectomy;

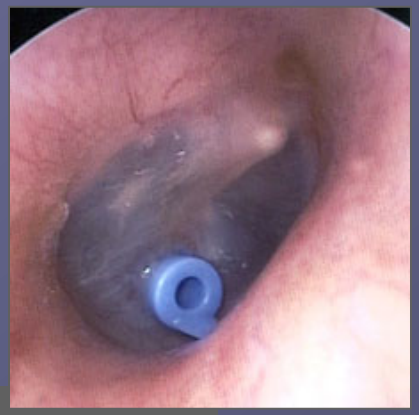
or

d. Obstructive sleep apnea as diagnosed by polysomnogram with an Apnea-Hypopnea Index (AHI) greater than 10

Clinical Practice Guideline: Tympanostomy Tubes in Children—Executive Summary

The American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF)

Otolaryngology -- Head and Neck Surgery 2013



STATEMENT 1. OME OF SHORT DURATION: Clinicians should *not* perform tympanostomy tube insertion in children with a single episode of OME of less than 3 months' duration, from the date of onset (if known) or from the date of diagnosis (if onset is unknown).

STATEMENT 3. CHRONIC BILATERAL OME WITH HEARING DIFFICULTY: Clinicians should offer tympanostomy bilateral tube insertion to children with bilateral OME for 3 months or longer AND documented hearing difficulties. *Recommendation based on RCTs and observational studies, with a preponderance of benefit over harm.*

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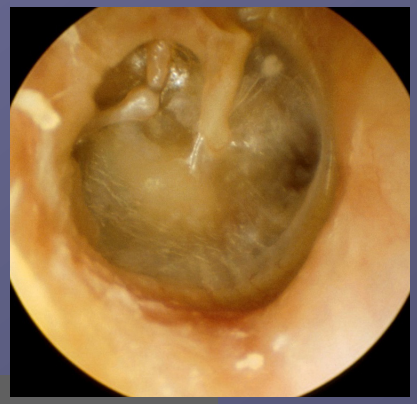

STATEMENT 4. CHRONIC OME WITH SYMPTOMS: **Clinicians may perform tympanostomy tube insertion in children with unilateral or bilateral OME for 3 months or longer (chronic OME) AND symptoms that are likely attributable to OME that include, but are not limited to, balance (vestibular) problems, poor school performance, behavioral problems, ear discomfort, or reduced QOL.**

STATEMENT 5. SURVEILLANCE OF CHRONIC OME: **Clinicians should reevaluate, at 3- to 6-month intervals, children with chronic OME who do not receive tympanostomy tubes, until the effusion is no longer present, significant hearing loss is detected, or structural abnormalities of the tympanic membrane or middle ear are suspected.**

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Otolaryngology -- Head and Neck Surgery 2013

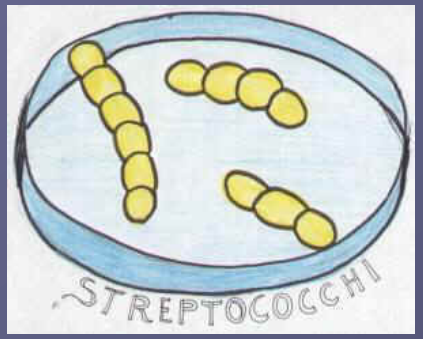
STATEMENT 9. TYMPANOSTOMY TUBES AND AT-RISK CHILDREN: Clinicians may perform tympanostomy tube insertion in at-risk children with unilateral or bilateral OME that is unlikely to resolve quickly, as reflected by a type B (flat) tympanogram or persistence of effusion for 3 months or longer.

Table 2. Risk factors for developmental difficulties.[a]

Permanent hearing loss independent of otitis media with effusion
Suspected or confirmed speech and language delay or disorder
Autism-spectrum disorder and other pervasive developmental disorders
Syndromes (eg, Down) or craniofacial disorders that include cognitive, speech, or language delays
Blindness or uncorrectable visual impairment
Cleft palate, with or without associated syndrome
Developmental delay

[a]Sensory, physical, cognitive, or behavioral factors that place children who have OME at increased risk for developmental difficulties (delay or disorder).[6]

Microbiologia - OMA



- *Streptococcus pneumoniae* (30-50%)
- *Haemophilus influenzae* (20-25%)
  [34-50% produttore di ß-lattamasi]
- *Moraxella catarrhalis* (10-20%)
  [70-100% produttore di ß-lattamasi]
- *Streptococcus piogenes* gruppo A (1-5%)
  [40% resistenza alle penicilline PBP]
- *Staphylococcus aureus*, batteri enterici gram- (*Escherichia coli, Klebsiella, Pseudomonas aeruginosa*), anaerobi
  - Nei bambini < 6 mesi gram- in circa il 20%

Microbiologia - OMA

- ✓ In circa il 16-25% delle OMA, versamento negativo per virus e batteri
- ✓ Nel 40-75% delle OMA presenti virus (*VRS, influenzali, parainluenzali, rinovirus, adenovirus*) nelle secrezioni delle VAS e/o nel versamento endotimpanico
- ✓ Il 5-22% dei versamenti negativi per batteri risulta positivo per virus

Criteri per l'indicazione al trattamento dell'OMA (*Am.Acad. of Pediatrics - Am.Acad. of Family Physicians, 2006)*

età	Diagnosi certa (+)	Diagnosi incerta
< 6 mesi	Terapia antimicrobica	Terapia antimicrobica
6-24 mesi	Terapia antimicrobica	Terapia antimicrobica se malattia severa; osservazione se non severa
> 24 mesi	Terapia antimicrobica se malattia severa; osservazione se non severa (*)	Osservazione

(+) insorgenza rapida; versamento, segni e sintomi di flogosi

(*) otalgia moderata e temperatura < 39°C

Antibiotics for acute otitis media in children (Review)

The Cochrane Library 2013, Issue 1

Venekamp RP, Sanders S, Glasziou PP, Del Mar CB, Rovers MM

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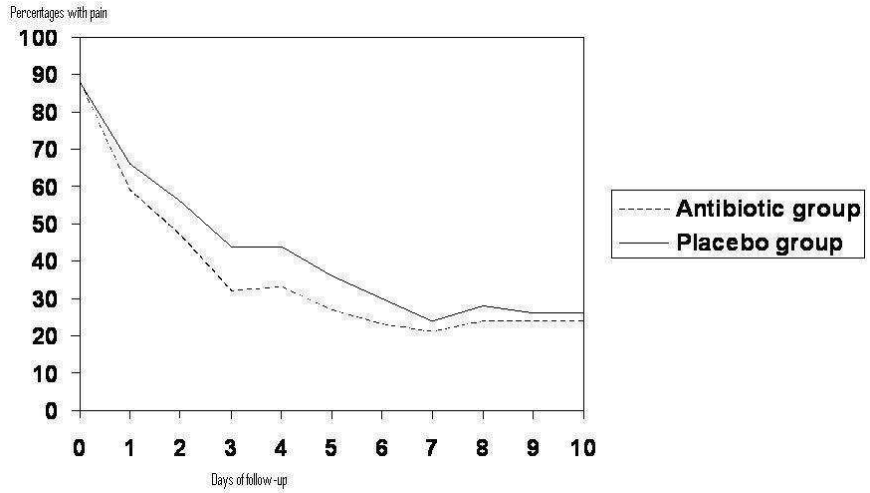
Authors' conclusions

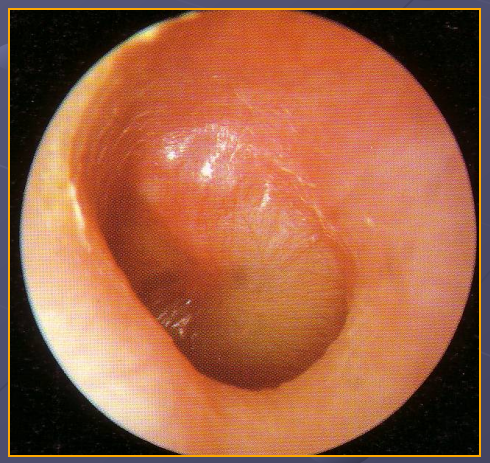
Antibiotic treatment led to a statistically significant reduction of children with AOM experiencing pain at two to seven days compared with placebo but since most children (82%) settle spontaneously, about 20 children must be treated to prevent one suffering from ear pain at two to seven days. Additionally, antibiotic treatment led to a statistically significant reduction of tympanic membrane perforations (NNTB 33) and contralateral AOM episodes (NNTB 11). These benefits must be weighed against the possible harms: for every 14 children treated with antibiotics, one child experienced an adverse event (such as vomiting, diarrhoea or rash) that would not have occurred if antibiotics had been withheld. Antibiotics appear to be most useful in children under two years of age with bilateral AOM, or with both AOM and otorrhoea. For most other children with mild disease, an expectant observational approach seems justified. We have no trials in populations with higher risks of complications.

Figure 6. Percentage with pain based on the subset of six studies included in the IPD Meta-analysis (Rovers et al 2006).



Vaccinazione antipneumococcica

- L'*American Academy of Pediatrics* (2000) ha raccomandato l'immunizzazione con PCV7 nei bambini fino a 5 anni con otite media ricorrente (cosiddetti "*otitis prone children*" - il 5-10% dei bambini)



CONCLUSIONI

- Le patologie delle vie aeree superiori in età pediatrica hanno come elemento causale fondamentale l'ipertrofia/flogosi adenoidea, attraverso meccanismi ostruttivi e di contaminazione microbica
- L'adenotomia (isolata o in associazione ad altre procedure) ha tuttora un ruolo fondamentale nel trattamento di tali affezioni
- La vigile attesa, unita a una adeguata terapia medica, risulta spesso risolutiva consentendo di evitare l'opzione chirurgica