Summary of Guideline Key Action Statements in Treatment of Otitis Media - American Academy of Otolaryngology Head& Neck Surgery FoundationAAO-HNSF, 2016		
Statement	Action	Strength
1a. Pneumatic otoscopy	The clinician should document the presence of middle ear effusion with pneumatic otoscopy when diagnosing otitis media with effusion (OME) in a child.	Strong recommendation
1b. Pneumatic otoscopy	The clinician should perform pneumatic otoscopy to assess for OME in a child with otalgia, hearing loss, or both.	Strong recommendation
2. Tympanometry	Clinicians should obtain tympanometry in children with suspected OME for whom the diagnosis is uncertain after performing (or attempting) pneumatic otoscopy.	Strong recommendation
3. Failed newborn hearing screen	Clinicians should document in the medical record counseling of parents of infants with OME who fail a newborn hearing screen regarding the importance of follow-up to ensure that hearing is normal when OME resolves and to exclude an underlying sensorineural hearing loss.	Recommendation
4a. Identifying at-risk children	Clinicians should determine if a child with OME is at increased risk for speech, language, or learning problems from middle ear effusion because of baseline sensory, physical, cognitive, or behavioral factors	Recommendation
4b. Evaluating at-risk children	Clinicians should evaluate at-risk children for OME at the time of diagnosis of an at-risk condition and at 12 to 18 months of age (if diagnosed as being at risk prior to this time).	Recommendation
5. Screening healthy children	Clinicians should not routinely screen children for OME who are not at risk (Table 3) and do not have symptoms that may be attributable to OME, such as hearing difficulties, balance (vestibular) problems, poor school performance, behavioral problems, or ear discomfort.	Recommendation (against)
6. Patient education	Clinicians should educate families of children with OME regarding the natural history of OME, need for follow-up, and the possible sequelae.	Recommendation
7. Watchful waiting	Clinicians should manage the child with OME who is not at risk with watchful waiting for 3 months from the date of effusion onset (if known) or 3 months from the date of diagnosis (if onset is unknown).	Strong recommendation
8a. Steroids	Clinicians should recommend against using intranasal steroids or systemic steroids for treating OME.	Strong recommendation (against)
8b. Antibiotics	Clinicians should recommend against using systemic antibiotics for treating OME.	Strong recommendation (against)
8c. Antihistamines or decongestants	Clinicians should recommend against using antihistamines, decongestants, or both for treating OME.	Strong recommendation (against)
9. Hearing test	Clinicians should obtain an age-appropriate hearing test if OME persists for _3 months or for OME of any duration in an at-risk child.	Recommendation
10. Speech and language	Clinicians should counsel families of children with bilateral OME and documented hearing loss about the potential impact on speech and language development.	Recommendation
11. Surveillance of chronic OME	Clinicians should reevaluate, at 3- to 6-months intervals, children with chronic OME until the effusion is no longer present, significant hearing loss is identified, or structural abnormalities of the eardrum or middle ear are suspected.	Recommendation
12a. Surgery for children\4 y old	Clinicians should recommend tympanostomy tubes when surgery is performed for OME in a child less than 4 years old; adenoidectomy should not be performed unless a distinct indication (eg, nasal obstruction, chronic adenoiditis) exists other than OME.	Recommendation
13. Outcome assessment	When managing a child with OME, clinicians should document in the medical record resolution of OME, improved hearing, or improved quality of life.	Recommendation