Michael A. Schmidt
Healing Childhood Ear Infections

Leseprobe

Healing Childhood Ear Infections
von Michael A. Schmidt
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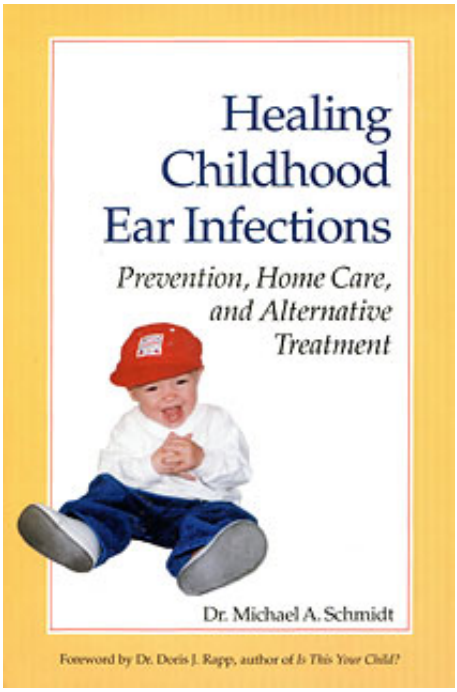

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that a subcategory of susceptible children who are given antibiotics experience overgrowth of fungi in the gut, which then produce substances toxic to the nervous system? If so, it would explain why some children appear to experience developmental delay following antibiotic therapy.

That I have chosen to present such preliminary evidence before it is confirmed experimentally is likely to produce outrage among some physicians. While I agree there should be no rush to judgment, I think the findings are so potentially profound that they deserve debate in an open forum. We have no clear explanation for the rise in developmental delays in modern culture. While it is undoubtedly complex, I believe we must candidly discuss and investigate every possibility. Meanwhile, we must be certain that antibiotic therapy does not put any child at risk, especially in cases where the potential for gain is minimal.

Antibiotics and Otitis Media: Helpful for Most Children?

There is evidence suggesting that antibiotics are effective in managing some types of middle ear infections. Members of a 1984 conference entitled "Controversies in Antimicrobial Agents for Otitis Media," chaired by Charles D. Bluestone, M.D., suggest that antimicrobial therapy *is* indicated for acute otitis media. Sulfonamides have been shown to be somewhat effective in treating ear infections.[35] Amoxicillin was found, in one trial, to be more effective than placebo in treating acute otitis media.[36] Researchers in Canada, after a study of 142 children, concluded that penicillin and ampicillin were superior to symptomatic therapy.[37] Such studies led many doctors to conclude that antibiotics were appropriate for almost any middle ear problem they encountered. However, this conclusion proved to be erroneous. Later studies showed that antibiotics worked best under very special conditions, i.e. when bacteria were shown to be present in the middle ear.

In many studies (as in daily practice), middle ear cultures are not performed to determine whether harmful bacteria exist.

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Dr. S. A. Carlin and colleagues completed a study of of children who were culture-positive for common middle ear bacteria. Sensitivity tests were performed to determine sensitivity of the bacteria to six different antibiotics. Treating only the children who tested positive for bacteria, 86 percent showed improvement.[38] Unfortunately, the percentage of children for whom antibiotics are useful may be low when compared with the number of children receiving antibiotics for otitis media. Supporting the latter contention are several studies conducted over the past two decades.

In a recent study involving 3,660 children and physicians from nine countries, antibiotic-treated children recovered at a rate slightly slower than children not receiving antibiotics.[39] Dr. F. L. Van Buchem compared children treated with antibiotics, antibiotics and myringotomy or no treatment and found little difference between the groups with regard to pain, level of hearing, healing time, recurrence and fever.[40]

In another study, Dr. Van Buchem reported on a study of 4,860 children with acute otitis media treated with pain relievers and nose drops for four days (without antibiotics or myringotomy). *More than* 90 *percent of these children recovered in a few days with no need for further treatment.* Three percent of cases were severe and required antibiotic therapy. Van Buchem concluded "treatment of acute otitis media in children can be limited to nose drops and analgesics for the first three to four days. An antibiotic, preferably penicillin, can be given in the severe cases (still ill after three to four days with persistent high temperature or severe pain, or both) and to patients who do not clinically appear to be ill but still have discharge of the ear after two weeks."[41]

After studying nearly four thousand children, two Dutch physicians concluded that 88 percent of children with acute otitis media never need antibiotics. They showed that when antibiotic treatment was instituted within the first two days of illness the rate of recurrence was 2.9 percent greater than if antibiotic treatment was delayed up to eight days (1.3 percent) or not used.[42]

In an article in the *Journal of the American Medical Association,* researchers reported that children with chronic otitis media with

effusion who received amoxicillin fared no better than those on placebo and, in fact, suffered two to six times greater recurrence than those on placebo. Similar findings were reported for Pediazole and cefaclor.[43]

Dr. John Bailar, the Scholar-in-Residence at the National Academy of Sciences' Institute of Medicine and editorial board member of the *New England Journal of Medicine*, reported on his analysis of the data regarding antibiotic treatment of otitis media. Commenting on the pattern of ineffectiveness he wrote, "This remarkable trend ... seems to demolish the conclusion that antibiotics improve the outcome [of otitis media]."[44]

A landmark article published in the *journal of the American Medical Association* had this to say following an extensive analysis of the existing research on antibiotics and chronic middle ear problems: "Antibiotics appear to have beneficial but limited effect on recurrent otitis media and short term resolution of otitis media with effusion [OME]. Longer term benefit for OME has not been shown."

The authors go on to say that, "Because a major goal of treatment of OME is the prevention of language or developmental delays due to hearing deficits, the lack of long term effectiveness leads one to question the value of antibiotic treatment."[45]

In countries such as Sweden, antibiotic treatment of otitis media is viewed with great caution. According to Karin Prellner, M.D., of the Swedish Medical Research Council, it would be difficult to conduct a placebo-controlled trial using antibiotics in otitis media in Sweden because antibiotics are viewed as an ineffective and potentially harmful form of therapy. She suggested that doctors there would be faced with a serious ethical conflict if they were forced to give antibiotics for what they consider a benign disorder, i.e. otitis media without complications.[46]

Robert Ruben, M.D., President of the American Society for Pediatric Otolaryngology, gave an address in which he seriously questioned the value of antibiotics in otitis media on three grounds: lack *of effectiveness, antibiotic-resistant bacteria, safety.*

He stated, "It would appear that the widespread use of antibiotics for otitis media with effusion has added to the creation of

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off work to care for their sick child, I'm concerned about leaving a large number of moderately ill children together in such a setting.

When Your Child Must Be on Antibiotics

There may be instances when antibiotics will be necessary for your child. Under these circumstances, you must make every effort to minimize the adverse impact of the antibiotic on your child. The first step is to give a bifidus supplement (see section below on intestinal bacteria), one teaspoon, three times per day during the ten-day course of the antibiotic. Doses of bifidus should be given between doses of the antibiotic. In cases of sulfa drug therapy, a two- to three-hour spacing between the bifidus and antibiotic is recommended.[16] Once the antibiotic has been discontinued, continue to give bifidus for one full month.

You also should discuss with your doctor the prospects of your child taking Nystatin with the antibiotic. Nystatin is an antifungal agent that will prevent the overgrowth of intestinal yeast that often accompanies antibiotic therapy. Tell your doctor that you are aware that antibiotics can kill the beneficial bacteria which live in the intestine, and that when this occurs, there is nothing to keep the yeast organisms in check. Convey to him that you realize the need for antibiotics in this situation, but would like to take this additional step for your child. (Incidentally, years ago some antimicrobial preparations contained both antibacterial agents and Nystatin in the same tablet for the reason just mentioned.)

I also recommend that you neither accept nor request an antibiotic prescription over the phone. If your child is sick enough to require an antibiotic, he is sick enough to be seen by a doctor. A doctor cannot discern the state of your child's illness from a telephone call.

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What If Your Doctor Recommends Adenoidectomy or Tubes?

Do not accept or reject surgery as a matter of course. If your child has had only a few ear infections and there are no signs of complications, you will want to approach the prospect of surgery with caution. Since ear infections are somewhat seasonal, I would be hesitant to agree to surgery if summer is just around the corner. If your doctor recommends tubes, remember that the likelihood of otorrhea (see chapter 3) is high during summer because of external contamination from swimming.

If your child has had recurrent earaches for some time that have not responded to any therapy, or there are signs of complications, you should consider tubes more realistically. In either case, I recommend that you get a second opinion from a doctor who is in no way associated with your doctor. Ask your friends and family to give you a recommendation, but don't get a referral from your doctor or his staff.

The ultimate decision rests with you. After you have considered all the evidence available to you and consulted with your doctors, you will need to decide what's best for your child. The information I presented in chapter 3 is not an indictment of tubes (or adenoidectomy) and I make no statement about the needs of an individual child. My intent is to present some hazards and complicating features of these procedures so that parents can weigh them against the potential benefits that might be afforded.

Climate Considerations

Fall, winter, and spring are seasons when ear infections are most common—winter being the most likely. An important consideration during these seasons is the relative humidity. In temperate regions such as Minnesota, the outdoor humidity in December falls to around 10 percent and below, while the indoor humidity can plummet to o to 5 percent. When the air is this dry, mucous mem-

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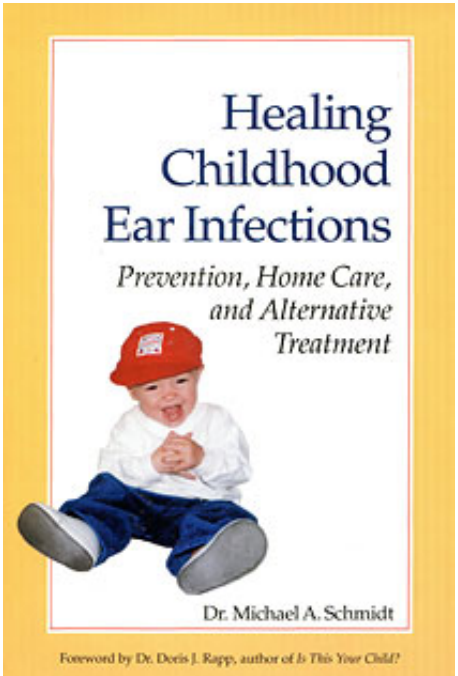

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