滲出性（しんしゅつせい）中耳炎に対する 鼓膜チューブ留置 の是非について

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１２才未満のお子さんで 鼓膜チューブ の留置 が適応になるのは、

１）滲出性中耳炎（中耳に液が貯まっている中耳炎・鼓膜は赤くない）が３か月以上続いていて、かつ 難聴を合併している場合である。

1)Ear tube surgery is indicated for otitis media with effusion that is present for three months that is associated with a hearing loss.

米国のガイドラインの要約は以下の通りです。

On May of 2004, the American Academy of Pediatrics Subcommittee on Otitis Media with Effusion; American Academy of Family Physicians; American Academy of Otolaryngology--Head and Neck Surgery printed guidelines for the treatment of **otitis media with effusion**.
They recommended the following in children age 12 years and under:

1) Ear tube surgery is indicated for otitis media with effusion that is present for three months that is associated with a hearing loss.
2) More promptly evaluate and intervene in children with speech, language or learning problems.
3) Intervene if structural abnormalities of the eardrum or middle ear develop.
4) Hearing tests should be performed on children with **otitis media with effusion** present for 3 months or longer.

--Initial management consists of ear tube placement, adenoidectomy should not be performed initially unless another indication for adenoidectomy exists.

**Clinical practice guideline: Otitis media with effusion.**
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The clinical practice guideline on otitis media with effusion (OME) provides evidence-based recommendations on diagnosing and managing OME in children. This is an update of the 1994 clinical practice guideline "Otitis Media With Effusion in Young Children," which was developed by the Agency for Healthcare Policy and Research (now the Agency for Healthcare Research and Quality).
In contrast to the earlier guideline, which was limited to children aged 1 to 3 years with no craniofacial or neurologic abnormalities or sensory deficits, the updated guideline applies to children aged 2 months through 12 years with or without developmental disabilities or underlying conditions that predispose to OME and its sequelae.
The American Academy of Pediatrics, American Academy of Family Physicians, and American Academy of Otolaryngology-Head and Neck Surgery selected a subcommittee composed of experts in the fields of primary care, otolaryngology, infectious diseases, epidemiology, hearing, speech and language, and advanced practice nursing to revise the OME guideline.
The subcommittee made a strong recommendation that clinicians use pneumatic otoscope as the primary diagnostic method and distinguish OME from acute otitis media (AOM). The subcommittee made recommendations that clinicians should (1) document the laterality, duration of effusion, and presence and severity of associated symptoms at each assessment of the child with OME; (2) distinguish the child with OME who is at risk for speech, language, or learning problems from other children with OME and more promptly evaluate hearing, speech, language, and need for intervention in children at risk; and (3) 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 from the date of diagnosis (if onset is unknown). The subcommittee also made recommendations that (4) hearing testing be conducted when OME persists for 3 months or longer, or at any time that language delay, learning problems, or a significant hearing loss is suspected in a child with OME; (5) children with persistent OME who are not at risk should be reexamined at 3- to 6-month intervals until the effusion is no longer present, significant hearing loss is identified, or structural abnormalities of the eardrum or middle ear are suspected; and (6) when a child becomes a surgical candidate, tympanostomy tube insertion is the preferred initial procedure. Adenoidectomy should not be performed unless a distinct indication exists (nasal obstruction, chronic adenoiditis); repeat surgery consists of adenoidectomy plus myringotomy, with or without tube insertion. Tonsillectomy alone or myringotomy alone should not be used to treat OME. The subcommittee made negative recommendations that (1) population-based screening programs for OME not be performed in healthy, asymptomatic children and (2) antihistamines and decongestants are ineffective for OME and should not be used for treatment; antimicrobials and corticosteroids do not have long-term efficacy and should not be used for routine management.

The subcommittee gave as options that (1) tympanometry can be used to confirm the diagnosis of OME and (2) when children with OME are referred by the primary clinician for evaluation by an otolaryngologist, audiologist, or speech-language pathologist, the referring clinician should document the effusion duration and specific reason for referral (evaluation, surgery), and provide additional relevant information such as history of AOM and developmental status of the child. The subcommittee made no recommendations for (1) complementary and alternative medicine as a treatment for OME based on a lack of scientific evidence documenting efficacy and (2) allergy management as a treatment for OME based on insufficient evidence of therapeutic efficacy or a causal relationship between allergy and OME. Last, the panel compiled a list of research needs based on limitations of the evidence reviewed. The purpose of this guideline is to inform clinicians of evidence-based methods to identify, monitor, and manage OME in children aged 2 months through 12 years. The guideline may not apply to children older than 12 years because OME is uncommon and the natural history is likely to differ from younger children who experience rapid developmental change. The target population includes children with or without developmental disabilities or underlying conditions that predispose to OME and its sequelae. The guideline is intended for use by providers of health care to children, including primary care and specialist physicians, nurses and nurse practitioners, physician assistants, audiologists, speech-language pathologists, and child development specialists. The guideline is applicable to any setting in which children with OME would be identified, monitored, or managed. This guideline is not intended as a sole source of guidance in evaluating children with OME. Rather, it is designed to assist primary care and other clinicians by providing an evidence-based framework for decision-making strategies. It is not intended to replace clinical judgment or establish a protocol for all children with this condition, and may not provide the only appropriate approach to diagnosing and managing this problem.