Non traumatic otorrhoea

Suction toilet the ear

Take a swab for MCS including fungi and request sensitivity to ototopical medications with copy to patient's GP

Assess discharge, canal oedema, integrity of tympanic membrane and history of chronic ear disease or past ear surgery

Tympanic membrane definitely intact

Not sure

Definite tympanic membrane perforation (TMP) visible or patient reports pre-existing TMP or middle ear ventilation tube in situ

Otorrhoea is often painless

Canal oedema +

Pain+++

Black white grey yellow green debris +/- spores

LIKELY FUNGAL OTITIS EXERNA

Canal oedema +++

Pain ++

Yellow-white discharge

LIKELY BACTERIAL OTITIS EXTERNA

Blood stained discharge Ciproxin HC

No blood

Ciloxan

Allergy to ciprofloxacin chloromycetin drops (Chlorsig eye drops)

Steroid plus anti-fungal drop

Locacorten Vioform 5 drops twice daily 10 days

Insert otowick if canal too oedematous for ear drops to penetrate

Prescribe steroid plus antibiotic drop

Ciproxin HC 5 drops twice a day ten days

OR

Sofradex 5 drops twice a day ten days

Insert otowick if canal too oedematous for ear drops to penetrate

All drops: 5 drops twice a day ten days

If wick inserted, arrange review in 48-72 hours to change wick

Continue drops as prescribed

How to use ear drops:
https://www.youtube.com/watch?v=v0HODFTrkqs

Keep ear dry

How to use ear drops:
https://www.youtube.com/watch?v=v0HODFTrkqs

Review in ED or with GP in 4-5 days for swab result and to ensure responding to treatment

Suspect skull base osteitis (malignant otitis externa) if your patient is immunosuppressed, diabetic or has severe intractable pain despite 48 hours of adequate topical treatment

Otorrhoea with ventilation tubes is not normal and should be treated as above, within 24-48 hours of commencing. Ciloxan is available on authority script for children with TMP or ventilation tube and ATSI patients of any age

Sofradex, like gentamicin, is ototoxic and should not be used when the tympanic membrane is not intact