Assessment of clinical and pathogenic aspects of Otitis media

Dr. K Mahendran, Dr. Praveen Kumar and Dr. Priyadershini Rangari

DOI: https://doi.org/10.33545/surgery.2020.v4.i2a.388

Abstract

Background: Otitis media (OM) is a group of complex infective and inflammatory conditions affecting the middle ear, with a variety of subtypes differing in presentation, associated complications, and treatment. A number of diseases of the middle ear are summed up under the term otitis media: acute otitis media, recurrent acute otitis media, otitis media with effusion, chronic supplicative otitis media and chronic otitis media epitympanalis (= cholesteatoma).

Objectives: Hence, under the light of above mentioned data, the present study was undertaken for assessing the clinical and pathogenic aspects of chronic otitis media.

Methods: A total of 25 patients with confirmed diagnosis of otitis media were enrolled in the present study. Middle-ear discharge was taken from each subject and were placed on thioglycollate broth media and immediately sent to the pathogenic analysis. The swab samples were cultured on 5 per cent sheep blood agar, and chocolate agar for isolation of aerobic bacteria, and incubated aerobically at 37°C for 24–48 hours. Identification of the isolates grown was done by using different microbiological methods. All the results were analyzed by SPSS software.

Results: Earache and ear discharge were found to be the prominent clinical manifestation. Deafness and pain were found to be the other presenting symptoms. While assessing the pathogenic profile, it was observed that coagulase-negative staphylococci, S aureus, P aeruginosa, Klebsiella spp. and Proteus spp. were present in 11 males and 10 females. S aureus was found to be present in 10 males and 5 females, P aeruginosa was found to be present in 11 males and 5 females, Klebsiella spp. were found to be present in 13 males and 4 females. Non-significant results were obtained while assessing the distribution of patients with different clinical profile according to gender. Coagulase-negative staphylococci were seen in 12 males and 8 females. S aureus was found to be present in 10 males and 5 females, P aeruginosa was found to be present in 11 males and 5 females, Klebsiella spp. were found to be present in 8 males and 4 females. Non-significant results were obtained while assessing the microbial growth among patients divided on the basis of gender.

Conclusion: Earache and ear discharge are the most common presenting symptom of chronic otitis media with coagulase-negative staphylococci and S. aureus being the prominent micro-organism responsible for it.

Keywords: Chronic supplicative otitis media (CSOM), otitis media, culture, swab, tympanic membrane (TM)

Introduction

Otitis media (OM) is a group of complex infective and inflammatory conditions affecting the middle ear, with a variety of subtypes differing in presentation, associated complications, and treatment. OM is a leading cause of health care visits worldwide, and its complications are important causes of preventable hearing loss, particularly in the developing world [1-3].

A number of diseases of the middle ear are summed up under the term otitis media: acute otitis media, recurrent acute otitis media, otitis media with effusion, chronic supplicative otitis media and chronic otitis media epitympanalis (= cholesteatoma). Acute otitis media belongs to the most common pediatric diseases and is often caused by bacterial infection. Since the advent of pneumococcal vaccines the quantity of AOM caused by pneumococci has declined; vaccination against NTHi and Moraxella catarrhalis is being developed. Dysfunction of the Eustachian tube often underlies OM. Manometric measurement of Eustachian tube function may be useful for indication of balloon Eustachian tuboplasty. Several theories explain pathogenesis of cholesteatoma and multiple pro-inflammatory processes promote its progress in the course of the disease [4-6].

The most common cause of OM is bacterial infection of the middle ear. AOM is predominantly caused by Streptococcus pneumoniae, Haemophilus influenzae and Moraxella catarrhalis.
However, *Pseudomonas aeruginosa* and *Staphylococcus aureus* are the most common aerobic microbial isolates in patients with CSOM, followed by *Proteus vulgaris* and *Klebsiella pneumoniae*. A number of studies from different countries including India, Nepal, Singapore and Nigeria have reported that *P. aeruginosa* is the most common pathogen that causes CSOM, followed by *S. aureus*. However, studies from gulf countries reported *S. aureus* as the most predominant pathogen, followed by *P. aeruginosa*. The difference in the various studies could be due to the differences in the patient population studied and geographical variation [7].

CSOM is usually classified into two types, tubotympanic and atticanostral depending on whether the disease process affects the pars tensa or pars flaccida of the tympanic membrane (TM). Tubotympanic is called as a safe type or benign type as there is no serious complication whereas, atticanostral is called as the unsafe or dangerous type because of associated complication and may be life threatening at times. Infection can spread from middle-ear to vital structures such as mastoid, facial nerve, labyrinth, lateral sinus, meninges and brain leading to mastoid abscess, facial nerve, paralysis, deafness, lateral sinus thrombosis, meningitis and intracranial abscesses. Of all the complications, hearing loss associated with chronic ear discharge is nearly always significant, reported in 50% of cases and tending to be more severe than those reported in other types of otitis media [8, 9].

Age appropriate audiometry and tympanometry should be tested in patients with otitis media with effusion. A ‘flat’ tympanogram will support a diagnosis of otitis media with effusion. Hearing can be tested in infants with the use of auditory brainstem responses (ABR). This exam tests the electrical activity of the brainstem to acoustic stimuli. The test detects both the frequency range and sound intensity levels in which the patient’s brain responds. Patients do not need to be able to speak and do not even need to be awake to perform the test. Therefore, it is ideal for children from birth to 5 years of age. With older children and adults, although ABR testing can still be performed, it is more common to do a classic audiometry exam. This exam consists of playing sounds to the patient’s left and right ears at different tones and intensities. Patients are requested to raise either the right or left hand when they hear a sound in the right or left ears, respectively. Individuals with normal hearing can detect lower frequencies at a lower decibel (i.e., intensity) than higher frequencies, meaning that a normal individual needs a sound to be louder to perceive high frequencies than lower frequencies. During an audiology exam, the range of frequencies that an individual can perceive is plotted on an audiogram. The decibel (dB) range of individuals with OME is decreased in the audiograph [10]. Many previous studies have investigated the prevalence and risk factors of COM. Its reported prevalence in Southeast Asia, Africa, and Western Pacific countries is 2–4%, and that in North America and European countries is < 2%. Risk factors of COM include low socioeconomic status, malnutrition, high number of children in the household, family history, and passive exposure to smoking. However, most studies have involved children, and have confined the study of otitis media to chronic suppurative otitis media, acute otitis media, or otitis media with effusion. Moreover, the effects of various host and environmental factors have not been well defined. Information on the risk factors of COM would contribute to effective treatment and control of this disease [8–10]. Hence; under the light of above mentioned data, the present study was undertaken for assessing the clinical and pathogenic aspects of chronic otitis media.

### Materials and Methods

The present study was conducted on 25 patients of either sex, in the department of ENT, Government Mohan Kumaramangalam Medical College, Salem, Tamil Nadu, in the time period of one year from August 2018 to August 2019. The study was performed with the aim of assessing the clinical and pathogenic profile of otitis media patients. Ethical approval was obtained from institutional ethical committee and written consent was obtained from all the patients after explaining in detail the entire research protocol.

A total of 25 patients with confirmed diagnosis of otitis media were enrolled in the present study. Exclusion criteria for the present study included:

- Patients with history of any other systemic illness,
- Patients with any known drug allergy,
- Diabetic and hypertensive patients,
- Patients who refused to give informed consent

A pretested questionnaire was used containing open questions and the patients were assessed clinically. Middle-ear discharge was taken from each subject and were placed on thioglycollate broth media and immediately sent to the pathogenic analysis. The swab samples were cultured on 5 per cent sheep blood agar, and chocolate agar for isolation of aerobic bacteria, and incubated aerobically at 37 °C for 24–48 hours. Identification of the isolates grown was done by using different microbiological methods. All the results were analyzed by SPSS software. Chi-square test was used for assessment of level of significance. P-value of less than 0.05 was taken as significant.

### Results

In the present study, a total of 25 patients with chronic otitis media were enrolled. Mean age of the patients was found to be 20.8 years. 48 percent of the patients belonged to the age group of less than 30 years. 60 percent of the patients were males while the remaining were females. 72 percent of the patients had rural residence while the remaining had urban residence. In the present study, earache and ear discharge were found to be the prominent clinical manifestation. Deafness and pain were found to be the other presenting symptoms. While assessing the pathogenic profile, it was observed that coagulase-negative staphylococci, * S. aureus*, *P. aeruginosa*, *Klebsiella* spp. and *Proteus* spp. were present in 80 percent, 60 percent, 64 percent, 48 percent and 40 percent of the cases. Earache was present in 14 males and 9 females. Ear discharge was present in 15 males and 10 males. Deafness was present in 9 males and 6 females. Pain was present in 6 males and 4 females. Non-significant results were obtained while assessing the distribution of patients with different clinical profile according to gender. In the present study, Coagulase-negative staphylococci were seen in 12 males and 8 females. *S. aureus* was found to be present in 10 males and 5 females. *P. aeruginosa* was found to be present in 11 males and 5 females. *Klebsiella* spp. were found to be present in 8 males and 4 females. Non-significant results were obtained while assessing the microbial growth among patients divided on the basis of gender.

### Discussion

OM is pathology of the middle ear and middle ear mucosa, behind the ear drum (tympanic membrane). The middle ear is a cavity containing the ear ossicles (malleus, incus, and stapes), with the eustachian tube placed anteriorly (leading to the nasopharynx), the mastoid air cells posteriorly, tympanic membrane laterally, and the inner ear medially. Other important
nearby structures are the brain and meninges superiorly and the
signoid sinus posteriorly, and any infection of the middle ear
can spread to surrounding structures with serious results. The
middle ear is lined by modified respiratory epithelium, including
ciliated cells and goblet cells; the epithelium produces mucins
that are normally transported down the eustachian tube [5, 6].

Different types of OM present in different ways. Acute OM
(AOM) usually affects children aged under 2 years, and presents
with acute onset symptoms and signs of otalgia and fever, in a
child that is systemically unwell. It is acute inflammation, and
may be caused by bacteria or viruses. A particular subtype of
AOM is acute suppurative OM, which is characterized by the
presence of pus in the middle ear. If the ear drum perforates (this
occurs in approximately 5%, although higher rates have been
reported) then ear discharge will be present also; the perforation
usually heals spontaneously. AOM is one of the commonest
childhood infectious diseases; in the majority of cases the
disease is self-limiting, but it has high morbidity, although
mortality rates are generally low [7].

Many environmental, anatomical, and other factors contribute
to both the prevalence of middle ear infections in children and the
chronicity or recurrent nature of OM. These factors include the
immaturity of the pediatric immune system, existence of other
ongoing infections, the anatomic positioning of the Eustachian
tube in childhood, genetic predisposition, methods of feeding,
smoking in the household, existence of allergies, and attendance
at day care, among others. In addition, while children do mount
an immune response both systemically as well as locally to the
organism(s) present in their middle ears, due to the vast
heterogeneity of the microorganisms that cause OM, this
immune response does not confer protection against subsequent
bouts of OM. Whereas the multifactorial nature of middle ear
infections is well acknowledged, it has only recently become
fully appreciated that OM, both acute and chronic, is also a truly
polymicrobial infection involving any of several URT viruses
and one or more of three primary bacterial pathogens of the
middle ear. This delayed understanding was partly due to
difficulty in obtaining sequential samples from the middle ear
for assay by culture and the fact that many middle ear fluids (or
effusions) that were retrieved, in particular, from cases of
chronic OM, were culture negative [8-11]. Hence; under the light
of above mentioned data, the present study was undertaken for
assessing the clinical and pathogenic aspects of chronic otitis
media.

In the present study, mean age of the patients was found to be
20.8 years. 48 percent of the patients belonged to the age group
of less than 30 years. 60 percent of the patients were males while
the remaining were females. 72 percent of the patients had rural
residence while the remaining had urban residence. Neogi R et
al. assessed the clinico-epidemiological profile, perceptions and
clinical profile of the chronic supplicative otitis media (CSOM)
patients in a tertiary care hospital. A pretested questionnaire
was used containing open questions and the patients were assessed
clinically. Most patients (31.2%) were from 0-10 years age
group and were males (58.8%). Majority of them (96%) lived in
"kuccha" houses/slums, 76.8% practised unhygienic ear
pricking, 36.8% poured oil in their ears, 70.8% bathed in
ponds/rivers, 52.8% had ear discharge for more than 1 year.
Among the respondents, 17.2% knew that CSOM was
toxic, 24% thought CSOM ran in family, 20% knew
CSOM is preventable. There was low threat perception and long
time to seek care. Patients mostly presented with earache,
deafness and discharge, most had deafness and safe variety of
CSOM. More than half had comorbidities. Most of the previous
study findings corroborated with the present study. Here was a
substantial delay between the onset and treatment seeking due to
lack of awareness and low threat perception. Pain and
complications were the triggers for care-seeking [12].

In the present study, earache and ear discharge were found to be
the prominent clinical manifestation. Deafness and pain were
found to be the other presenting symptoms. While assessing the
pathogenic profile, it was observed that coagulase-negative
staphylococci, S aureus, P aeruginosa, Klebsiella spp. and
Proteus spp. were present in 80 percent, 60 percent, 64 percent,
48 percent and 40 percent of the cases. Vikram BK et al.
compared the clinical and epidemiological profiles of cases of
complicated and uncomplicated chronic supplicative otitis
media, based on their prognostic factors. The study group
comprised 187 ears, out of which 62 had complications while
125 did not. The two groups were compared with respect to nine
prognostic variables: age distribution, sex, patient's domicile,
literacy status, duration of ear discharge at presentation, ear
pathology, predisposing disease focus in the nose or throat, ear
swab microbiology, and hearing loss. Patients in the complicated
chronic supplicative otitis media group had a higher male
predominance and were younger. Rural and illiterate patients
had a higher risk of developing complications. Cholesteatoma
and granulation tissue were potential risk factors in the
complicated chronic supplicative otitis media group. Ears with
complications were more prone to develop sensorineural hearing
loss. Age, sex, duration of ear discharge, predisposing disease
focus in nose or throat, and ear swab microbiology were all less
useful prognostic indicators of complications. Early detection
and timely treatment of chronic supplicative otitis media in rural
and illiterate patients may prevent life-threatening complications
and reduce their incidence [13].

In the present study, earache was present in 14 males and 9
females. Ear discharge was present in 15 males and 10 males.
Deafness was present in 9 males and 6 females. Pain was present
in 6 males and 4 females. Non-significant results were obtained
while assessing the distribution of patients with different clinical
profile according to gender. With sensitive assays including
culture, polymerase chain reaction and antigen detection,
bacteria, viruses, or both, are detected in middle ear fluid in up
to 96% of AOM cases. A study of middle ear fluid in 79
children with AOM and indwelling tympanostomy tubes found
that 66% had bacteria and viruses, 27% had bacteria alone, and
4% had only viruses. The microbiology of AOM has changed
over the last 2 decades with increasing penetration of
pneumococcal vaccination programs. The most common
bacterial species that cause AOM continue to be Streptococcus
pneumoniae, non-typeable Haemophilus influenza, and
Moraxella catarrhalis. The heptavalent S pneumoniae vaccine
(PCV) was introduced in 2000, shortly after which the frequency
of S pneumoniae recovery in tympanocentesis studies of AOM
decreased relative to that of the other microbes. The S
pneumoniae serotypes contained in PCV continued to decline in
AOM patients, and were in fact nearly absent by 2007 through
2009. However, they have been replaced by nonvaccine
pneumococcal serotypes in both tympanocentesis and
nasopharyngeal colonization studies, so that the incidence of S
pneumoniae was approximately equal to that of H influenza,
with M catarrhalis less frequent. The new 13-valent S
pneumoniae vaccine, PCV, was licensed in 2010 and will
undoubtedly additionally shift the microbiological landscape of
AOM [14-16]. Deb T et al. assessed the types of aerobic bacteria
involved in CSOM. Aural swabs were collected from 100 ears,
from 97 patients complaining of ear discharge, continuous or
intermittent, with a non-intact tympanic membrane for at least 12 weeks. Swabs were sent to the hospitals microbiology laboratory for culture and sensitivity tests. Bacteria could be isolated in 53 cases and 47 swabs were culture negative. The commonest bacteria isolated were pseudomonas (20) followed by Staphylococcus aureus (11), E. coli (11), proteus (9) and klebsiella (2). Three patients had bilateral ear discharge of which one had proteus in both ear swabs, one grew proteus in one ear and no growth in the other, and one patient showed no aerobic bacteria in any of his ear swabs. Among the culture positive cases (n = 53) gram negative bacteria were isolated in 79.24% (n = 42) and S. aureus in 11 (20.75%) cases. Among 97 patients number of male and female patients was 50 and 47, respectively. Pseudomonas, E. coli, Bacilli proteus and S. aureus were the predominant bacteria involved in CSOM. Out of the 53 positive isolates ciprofloxacin could be tested against 35 i.e., 66%. Ciprofloxacin was sensitive in 26 isolates, intermittently sensitive in 4 and resistant in only five isolates. They concluded that gram negative bacteria especially pseudomonas is the commonest bacteria involved in CSOM in this part of north east India [17].

In the present study, Coagulate-negative staphylococci were seen in 12 males and 8 females. S aureus was found to be present in 10 males and 5 females. P aeruginosa was found to be present in 11 males and 5 females. Klebsiella spp. were found to be present in 8 males and 4 females. Non-significant results were obtained while assessing the microbial growth among patients divided on the basis of gender. Abraham ZS et al. determine the prevalence and etiological agents for chronic supplicative otitis media. A total of 5591 patients were recruited and only 79 (1.4%) had chronic supplicative otitis media. A male preponderance 43 (54.4%) was noted in this study and the left ear (58.2%) was more commonly affected compared to the right ear. Central perforation was the commonest pattern of presentation and was reported in 53% of cases though none had attic perforation. Of the 81 processed ear swabs, microbial growth was seen in majority 80 (98.8%) whilst one sample showed no microbial growth whereas 52.5% had polymicrobial growth. Among the isolates, most were gram negative species accounting for 59.7% while gram positive bacteria accounted for 25.6% and fungi accounted for 14.7%. Most of these isolates were facultative anaerobes. Klebsiella pneumoniae (20.2%) was the commonest isolates while Escherichia coli and Pseudomonas aeruginosa were equally least isolated (10.9%). Tested isolates were most sensitive to Ciprofloxacin, Gentamycin, Ceftriaxone and Amikacin and least sensitive to Amoxicillin/clavulanic acid and Ampicillin [18].

### Table 1: Demographic data

| Parameter         | Number | Percentage |
|-------------------|--------|------------|
| Age group (years) |        |            |
| Less than 30      | 12     | 48         |
| 30 to 50          | 8      | 32         |
| More than 50      | 5      | 20         |
| Gender            |        |            |
| Male              | 15     | 60         |
| Female            | 10     | 40         |
| Residence         |        |            |
| Rural             | 18     | 72         |
| Urban             | 7      | 28         |

### Table 2: Clinical profile

| Clinical profile | Number | Percentage |
|------------------|--------|------------|
| Earache          | 23     | 90         |
| Ear discharge    | 25     | 100        |
| Deafness         | 15     | 60         |
| Pain             | 10     | 40         |
| Others           | 5      | 20         |

### Table 3: Pathogenic profile

| Pathogenic profile           | Number | Percentage |
|------------------------------|--------|------------|
| Coagulate-negative staphylococci | 20     | 80         |
| S aureus                     | 15     | 60         |
| P aeruginosa                 | 16     | 64         |
| Klebsiella spp.              | 12     | 48         |
| Proteus spp.                 | 10     | 40         |
| No growth                    | 1      | 4          |

### Table 4: Clinical profile among males and females

| Clinical profile | Gender |
|------------------|--------|
|                  | Males  | Females |
| Earache          | 14     | 9       |
| Ear discharge    | 15     | 10      |
| Deafness         | 9      | 6       |
| Pain             | 6      | 4       |
| Others           | 3      | 2       |
| Chi-square value | 1.45   |         |
| p-value          | 0.12   |         |

### Table 5: Pathogenic profile among patients divided on the basis of gender

| Pathogenic profile           | Gender |
|------------------------------|--------|
|                              | Males  | Females |
| Coagulate-negative staphylococci | 12     | 8       |
| S aureus                     | 10     | 5       |
| P aeruginosa                 | 11     | 5       |
| Klebsiella spp.              | 8      | 4       |
| Proteus spp.                 | 7      | 3       |
| No growth                    | 0      | 1       |
| Chi-square value             | 1.965  |         |
| p-value                      | 0.33 (Non-significant) |         |

### Conclusion

From the above results, the authors conclude that earache and ear discharge are the most common presenting symptom of chronic otitis media with coagulate-negative staphylococci and S aureus being the prominent micro-organism responsible for it.

### References

1. Faden H, Bernstein J, Brodsky L, Stanievich J, Ogra PL. Effect of prior antibiotic treatment on middle ear disease in children. Ann. Otol. Rhinol. Laryngol. 1992; 101:87-91.
2. Eskola J, Kilpi T, Palmu A, Jokinen J, Haapakoski J, Herva...
E et al. Efficacy of a pneumococcal conjugate vaccine against acute otitis media. N. Engl. J. Med. 2001; 344:403-409.

3. Doyle WJ, Skoner DP, White M, Hayden F, Kaplan AP, Kaliner MA et al. Pattern of nasal secretions during experimental influenza virus infection. Rhinology. 1996; 34:2-8.

4. Faden H. The microbiologic and immunologic basis for recurrent otitis media in children. Eur J Pediatr. 2001; 160:407-413.

5. Rosenfeld RM, Kay D. Natural history of untreated otitis media. Laryngoscope. 2003; 113(10):1645-1657.

6. Venekamp RP, Sanders S, Glasziou PP, Del Mar CB, Rovers MM. Antibiotics for acute otitis media in children [review] Cochrane Database Syst Rev. 2013; (1):CD000219.

7. Stool SE, Field MJ. The impact of otitis media. Pediatr Infect Dis J. 1989; 8(1):S11-S14.

8. Chesney J, Black A, Choo D. What is the best practice for acute mastoiditis in children? Laryngoscope, 2013 Epub.

9. van Zon A, van der Heijden GJ, van Dongen TM, Burton MJ, Schilder AG. Antibiotics for otitis media with effusion in children [review] Cochrane Database Syst Rev. 2012; 9:CD009163.

10. Kubba H, Pearson JP, Birchall JP. The aetiology of otitis media with effusion: a review. Clin Otolaryngol Allied Sci. 2000; 25(3):181-194.

11. Finkelstein Y, Ophir D, Talmi YP, Shabtai A, Strauss M, Zohar Y. Adult onset otitis media with effusion. Arch Otolaryngol Head Neck Surg. 1994; 120(5):517-527

12. Neogi R, Dan A, Maity K, Basak B, Basu D, Acharya M, Sengupta A et al. Clinico-epidemiological profile of chronic suppurative otitis media patients attending a tertiary care hospital. J Indian Med Assoc. 2011; 109(5):324-6.

13. Vikram BK, Khaja N, Udayashankar SG, Venkatesha BK, Manjunath D. Clinico-epidemiological study of complicated and uncomplicated chronic suppurative otitis media. J Laryngol Otol. Epub 2008; 122(5):442-6.

14. Ruohola A, Meurman O, Nikkari S et al. Microbiology of acute otitis media in children with tympanostomy tubes: prevalences of bacteria and viruses. Clin Infect Dis. 2006; 43(11):1417-22.

15. Casey JR, Adlowitz DG, Pichichero ME. New patterns in the otopathogens causing acute otitis media six to eight years after introduction of pneumococcal conjugate vaccine. Pediatr Infect Dis J. 2010; 29(4):304-9.

16. Grubb MS, Spaugh DC. Microbiology of acute otitis media, Puget sound region, 2005-2009. Clin Pediatr. 2010; 49(8):727-30.

17. Deb T, Ray D. A study of the bacteriological profile of chronic suppurative otitis media in agartala. Indian J Otolaryngol Head Neck Surg. 2012; 64(4):326-329. doi:10.1007/s12070-011-0323-6

18. Abraham ZS, Ntunaguzi D, Kahinga AA et al. Prevalence and etiological agents for chronic suppurative otitis media in a tertiary hospital in Tanzania. BMC Res Notes. 2019; 12(1):429. Published 2019 Jul 17. doi:10.1186/s13104-019-4483-x