

Managing otitis externa

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Otitis externa

- ▶ Common condition
- ▶ Multifactorial
 - ▶ Hypersensitivity disorders, parasites, foreign bodies
- ▶ Bacterial and/or fungal
- ▶ Many treatment options



Otitis externa

- ▶ Why does this patient have otitis externa?
 - ▶ Primary causes
 - ▶ Secondary causes
 - ▶ Factors
 - ▶ Predisposing
 - ▶ Perpetuating

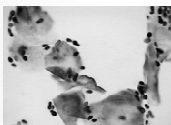
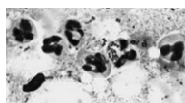
Primary causes



- ▶ Allergic disease
- ▶ Endocrine disease
- ▶ Immune-mediated disease
- ▶ Epithelialization disorders
- ▶ Foreign bodies
- ▶ Parasites

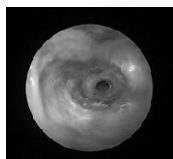
Secondary causes

- ▶ Bacteria
- ▶ Yeast
- ▶ Fungal



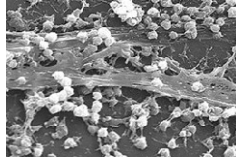
Predisposing factors

- ▶ Conformation
 - ▶ Stenotic canals, atresia, hypertrichosis, pendulous pinnae
- ▶ Excessive moisture
 - ▶ Frequent swimmer, overzealous flushing
- ▶ Quiz the owners!!!



Perpetuating factors

- ▶ Bacteria/Yeast
 - ▶ Biofilm production
- ▶ Otitis media
 - ▶ Packing material
- ▶ Pathologic changes
 - ▶ Hyperplasia



Otitis externa

- ▶ How do I diagnosis and begin management for otitis externa?
 - ▶ Clinical signs
 - ▶ Identify organisms
 - ▶ Choose the correct product

Otic examination

- ▶ Pinnae
- ▶ Otoscopic evaluation
- ▶ Tympanic membrane
 - ▶ Is it intact?
- ▶ Pruritus upon manipulation



Identify organisms

- ▶ Swab cytology on slide and heat fix
- ▶ Approximate number of organisms
- ▶ Discard older rules of infection



Ear flush

- ▶ When to use flush?
 - ▶ Partial response to therapy
 - ▶ Specific types of infections
 - ▶ Gram -
 - ▶ Otitis media

Ear flush

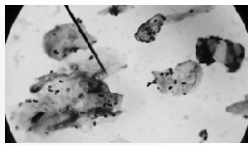
- ▶ General cleaning/Drying
 - ▶ EpiOtic (Virbac), GlycoZoo otic (DermaZoo)
- ▶ Ceruminolytic
 - ▶ Milytic flush (VetBiotek), Micellar solution (Douxo)
- ▶ Antimicrobial
 - ▶ MalAcetic Otic (Dechra), Miconatris (VetBiotek)

Topical therapy

- ▶ Antifungals
- ▶ Antibiotics
- ▶ Glucocorticoids

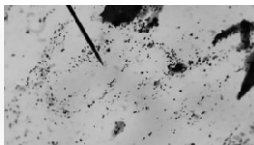


Antifungals



- ▶ Azole antifungals
 - ▶ Ketoconazole
 - ▶ Posaconazole
 - ▶ Miconazole
 - ▶ Clotrimazole
 - ▶ Climbazole
 - ▶ Thiabendazole
- ▶ Nystatin
- ▶ Silver sulfadiazine
- ▶ Terbinafine

Antibiotics



- ▶ Broad spectrum
- ▶ Fluoroquinolones
 - ▶ Marbofloxacin
 - ▶ Enrofloxacin
 - ▶ Orbifloxacin
- ▶ Aminoglycosides
 - ▶ Neomycin
 - ▶ Gentamicin

Glucocorticoids

- ▶ Triamcinolone
- ▶ Dexamethasone
- ▶ Prednisolone
- ▶ Hydrocortisone
- ▶ Betamethasone
- ▶ Mometasone



Medication

- ▶ Fungal otitis
 - ▶ Mometamax, Otomax, EasOtic, Tresaderm, Animax
- ▶ Fungal and Bacterial otitis (cocci)
 - ▶ Mometamax, Otomax, EasOtic, Tresaderm, Animax
- ▶ Bacterial otitis (cocci)
 - ▶ Surolan, Mometamax, Otomax, EasOtic, Tresaderm
- ▶ Bacterial otitis (rods or mixed)
 - ▶ Surolan, Baytril Otic, GentaOtic, Mometamax, Otomax, EasOtic

Medication

- ▶ Can I add in a steroid?
 - ▶ Considerable systemic absorption: Synotic (fluocinolone with dimethyl sulfoxide), injectable dexamethasone with saline
 - ▶ Minimal systemic absorption: Mometasone, Hydrocortisone aceponate
 - ▶ Oral steroids 0.5-2.0 mg/kg q24h

Bacterial culture

- ▶ Is an aerobic bacterial culture necessary?
 - ▶ Remains controversial
 - ▶ Middle ear involved and systemic therapy will be needed
 - ▶ Ruptured TM, opaque or diseased TM, Horner symptoms, chronic otitis externa
 - ▶ Biofilm = Poor response to therapy

Re-evaluating cases

- ▶ Ears should be re-evaluated in 2 weeks
 - ▶ Repeat cytology
 - ▶ New infection/change in organisms
 - ▶ Clients must see the value in ensuring that the infection is completely eliminated



Follow up

- ▶ Re-evaluate the cytology at all rechecks
- ▶ Normal flora vs. infection
 - ▶ Increased number of yeast or cocci bacteria in a treated, but normal looking ear should be treated for an additional 2 weeks
 - ▶ Ear that has not improved or has worsened
 - ▶ Have owners been compliant?
 - ▶ If so, then likely requires a switch of drug class or formulation
 - ▶ Consider referral for cases that do not respond to empirical antimicrobials, have suspected middle ear involvement, or structural abnormalities (stenosis, proliferative change)
