

Watchful Waiting in AOM: Which Children Can Safely Wait?

Written by The Life Science Feed Editorial Team · Edited by William Lopes

Acute otitis media (AOM) remains one of the most common reasons for antibiotic prescriptions in children, contributing significantly to antimicrobial resistance. The challenge for clinicians lies in identifying which children truly benefit from immediate antibiotics versus those who can safely undergo a period of watchful waiting. This approach aims to reduce unnecessary antibiotic use while preventing serious complications.

KEY TAKEAWAYS

- **The Pivot:** Watchful waiting is a viable, evidence-based strategy for AOM in carefully selected children, shifting away from routine immediate antibiotic prescription.
- **The Data:** Clinical guidelines support watchful waiting for children aged 6-23 months with unilateral AOM without severe symptoms, and for children 24 months and older with unilateral or bilateral AOM without severe symptoms.
- **The Action:** Clinicians should counsel parents on symptom management, follow-up, and criteria for initiating antibiotics, empowering them in the decision-making process.

Acute otitis media, an inflammation of the middle ear, is a prevalent childhood infection, particularly affecting infants and toddlers. The condition often presents with ear pain, fever, and irritability, leading many parents to seek immediate medical attention and, frequently, an antibiotic prescription. But the majority of AOM cases are viral or self-limiting bacterial infections, meaning antibiotics may offer little benefit and carry the risk of adverse effects and contribute to the broader problem of antimicrobial resistance. The question for general practitioners, then, is not whether to treat, but when and with what.

The standard approach to AOM has historically leaned towards prompt antibiotic therapy. This was largely driven by concerns over potential complications like mastoiditis or intracranial abscesses, though these are rare in developed countries. Over time, a growing understanding of the natural history of AOM and the increasing threat of antibiotic resistance has prompted a re-evaluation of this default strategy. The focus has shifted towards a more patient-centered approach, considering factors such as age, symptom severity, and diagnostic certainty. This evolution in thinking has led to the widespread adoption of watchful waiting as a legitimate management option for specific patient groups, a strategy also applied in other common infections to reduce antibiotic overuse, as seen in discussions around acute flaccid myelitis cases.

Defining the Watchful Waiting Strategy

Watchful waiting, or deferred antibiotic prescribing, involves observing a child's symptoms for a specified period, typically 24 to 48 hours, before initiating antibiotic treatment. During this period, symptomatic relief is provided with analgesics and antipyretics. Antibiotics are only prescribed if the child's symptoms worsen or do not improve within the observation window. This strategy requires clear communication with parents, ensuring they understand the rationale, the expected course of the illness, and the specific triggers for starting antibiotics or seeking further medical advice. The success of watchful waiting depends on parental adherence to monitoring and their ability to access follow-up care if needed. This shared decision-making process is important for empowering parents while ensuring appropriate medical oversight.

The criteria for safely implementing watchful waiting are well-established in clinical guidelines. These guidelines typically stratify recommendations based on the child's age, the certainty of the AOM diagnosis, and the severity of symptoms. For instance, a definitive diagnosis of AOM requires the presence of middle ear effusion, signs of inflammation of the tympanic membrane (e.g., bulging, erythema), and acute onset of symptoms. Without a clear diagnosis, antibiotics are often inappropriate, regardless of the waiting strategy.

Patient Selection and Symptom Severity

Age is a primary determinant in the decision-making process for watchful waiting. For infants younger than 6 months, immediate antibiotic treatment is generally recommended due to their immature immune systems and higher risk of serious bacterial infections. The stakes are higher in this vulnerable population, and the potential benefits of early intervention outweigh the risks of antibiotic exposure. For children aged 6 to 23 months, watchful waiting can be considered for unilateral AOM if symptoms are not severe. Severe symptoms in this age group typically include moderate to severe otalgia, otalgia for at least 48 hours, or a temperature of 39°C (102.2°F) or higher. If any of these severe symptoms are present, immediate antibiotics are usually indicated. The clinical judgment here is paramount, often relying on a thorough examination and a detailed history from parents.

Children 24 months and older represent the group most amenable to watchful waiting. For these older children, watchful waiting is a safe option for either unilateral or bilateral AOM, provided symptoms are not severe. The same definitions of severe symptoms apply: moderate to severe otalgia, prolonged otalgia, or high fever. The older a child is, the more likely their immune system can effectively clear the infection without antibiotic intervention. This demographic often experiences AOM as a self-resolving condition, making deferred prescribing a sensible choice. The ability of older children to communicate their symptoms more clearly also aids in parental monitoring and decision-making.

The Role of Diagnostic Certainty and Follow-Up

A necessary element in the safe application of watchful waiting is diagnostic certainty. A confident diagnosis of AOM, as opposed to otitis media with effusion (OME) or otitis externa, is essential. OME, characterized by fluid in the middle ear without signs of acute inflammation, does not warrant antibiotic treatment. Misdiagnosing OME as AOM can lead to unnecessary antibiotic use. Clinicians must use otoscopy effectively, looking for specific signs such as bulging of the tympanic membrane, limited or absent mobility of the tympanic membrane, and air-fluid levels. The 3M Littmann Classic III Stethoscope, while not for otoscopy, highlights the importance of reliable diagnostic tools in general practice. Effective follow-up is another cornerstone of successful watchful waiting. Parents must be given clear instructions on when to seek re-evaluation. This typically includes worsening symptoms (e.g., increased pain, higher fever), development

of new symptoms, or no improvement after the observation period. The observation period itself is usually 24 to 48 hours, but this can be extended slightly based on clinical judgment and parental comfort. The availability of timely follow-up appointments or clear guidance on when to present to an urgent care facility is vital to prevent complications. Without a robust follow-up plan, watchful waiting can become a risky proposition, undermining its intended benefits.

Benefits and Potential Pitfalls

The primary benefit of watchful waiting is the reduction of antibiotic exposure. This directly translates to fewer antibiotic-related adverse events, such as diarrhea, rash, and allergic reactions. More broadly, it helps to mitigate the development of antibiotic resistance, a public health crisis that demands judicious use of these vital medicines. By reserving antibiotics for cases where they are truly necessary, clinicians contribute to preserving their efficacy for future generations. This approach also aligns with broader public health initiatives to combat antimicrobial resistance, a topic frequently discussed in the context of unregulated drug promotion and its impact on prescribing habits.

But watchful waiting is not without its challenges. Parental anxiety is a significant factor. Many parents expect an antibiotic prescription and may be hesitant to defer treatment, fearing their child's condition will worsen. Clinicians must dedicate time to explain the rationale, provide reassurance, and offer clear instructions for symptom management. This educational component is important for successful implementation. The risk of complications, though low, is a persistent concern. While studies generally show no increase in serious complications with watchful waiting in selected populations, clinicians must remain vigilant for signs of worsening infection, such as facial paralysis, mastoiditis, or meningitis. These rare but serious events show the need for careful patient selection and robust follow-up protocols. The Oxford Handbook of Paediatrics offers a comprehensive guide to managing such conditions.

Addressing Parental Concerns and Communication

Effective communication is paramount when recommending watchful waiting. Clinicians should explain that AOM often resolves spontaneously and that antibiotics may not shorten the course of illness significantly in many cases. They should emphasize the potential side effects of antibiotics and the importance of reducing resistance. Providing a 'safety net' prescription, where parents are given a prescription to fill only if symptoms do not improve or worsen, can be a useful compromise. This approach addresses parental concerns about access to medication if needed, while still encouraging an initial period of observation. Clear, written instructions on symptom monitoring, pain relief, and when to start antibiotics or seek further medical attention are essential. This empowers parents to manage their child's illness confidently at home, knowing they have a plan in place.

The decision to implement watchful waiting must always be a shared one, involving the clinician and the parents. This collaborative approach builds trust and improves adherence to the management plan. Clinicians should assess parental understanding and comfort with the strategy, addressing any concerns or misconceptions. If parents are highly anxious or unable to commit to close monitoring, immediate antibiotic treatment might be the more pragmatic choice, even if the child technically meets the criteria for watchful waiting. The goal is to provide the best possible care while minimizing unnecessary interventions and promoting judicious antibiotic use. The details of such decisions are often covered in resources like the delegating tasks to medical assistants discussion, emphasizing the importance of clear protocols and communication in all aspects of primary care.

CLINICAL IMPLICATIONS

The shift towards watchful waiting in acute otitis media represents a critical evolution in pediatric primary care. For general practitioners, this means a more active role in patient education and shared decision-making, moving beyond the automatic antibiotic prescription. It demands confidence in clinical assessment and a willingness to challenge established norms, all while managing parental expectations and anxieties.

This strategy directly impacts the broader public health challenge of antimicrobial resistance. Every avoided antibiotic prescription, particularly in self-limiting conditions like AOM, contributes to preserving the efficacy of these drugs for more serious infections. It is a small but significant step in a much larger battle, one that requires consistent application across all levels of healthcare.

For parents, watchful waiting offers a pathway to understanding their child's illness more deeply and participating actively in their care. It can reduce the burden of unnecessary medication side effects and foster a more informed understanding of when antibiotics are truly beneficial. The success of this approach hinges on clear, empathetic communication from clinicians, ensuring parents feel supported and informed.

The judicious application of watchful waiting in AOM is a demonstration of evidence-based practice. This approach shows that sometimes, the best intervention is careful observation, coupled with robust patient education and a clear safety net. This approach benefits individual children by reducing antibiotic exposure and contributes to the collective good by slowing the relentless march of antimicrobial resistance.

EDITORIAL & AI STANDARDS

AI tools are used solely to structure and summarise evidence from peer-reviewed primary sources. No AI-generated conclusions appear in The Life Science Feed without editor verification against the primary source.

REFERENCES

1. El Feghaly RE, Nedved A, Katz SE, Frost HM. New insights into the treatment of acute otitis media. *Expert Rev Anti Infect Ther*. 2023;21(5):523-534. doi:10.1080/14787210.2023.2206565
2. Leung AKC, Wong AHC. Acute Otitis Media in Children. *Recent Pat Inflamm Allergy Drug Discov*. 2017;11(1):32-40. doi:10.2174/1874609810666170712145332
3. Gaddey HL, Wright MT, Nelson TN. Otitis Media: Rapid Evidence Review. *Am Fam Physician*. 2019;100(6):350-356. PMID:31524361
4. Harmes KM, Blackwood RA, Burrows HL, Cooke JM, Harrison RV, Passamani PP. Otitis media: diagnosis and treatment. *Am Fam Physician*. 2013;88(7):435-40. PMID:24134083
5. Castelli Gattinara G, Bergamini M, Simeone G, et al. Antibiotic treatment of acute and recurrent otitis media in children: an Italian intersociety Consensus. *Ital J Pediatr*. 2025;51(1):50. doi:10.1186/s13052-025-01894-z
6. Bustamante J, Tran T, Rodriguez CR. Otitides: Acute and Chronic Otitis Media and Externa. *Prim Care*. 2025;52(1):1-14. doi:10.1016/j.pop.2024.09.003

LICENCE & RIGHTS

© 2026 The Life Science Feed. All rights reserved. This content is produced for medical education purposes. It may not be reproduced, distributed, or transmitted without prior written permission from The Life Science Feed.

MEDICAL DISCLAIMER

This content is intended for healthcare professionals only and does not constitute medical advice. Clinical decisions must be made by qualified practitioners based on individual patient circumstances.

FOLLOW THE LIFE SCIENCE FEED

Instagram @lifesciencefeed **LinkedIn** linkedin.com/company/thelifesciencefeed

thelifesciencefeed.com