

Ear Infections and Tubes with Adenoidectomy

Surgical Information



MED
CENTER
HEALTH

ENT Bowling Green

To Patients Scheduled for Surgery:

On your day of surgery, there are some “scheduled inefficiencies” built into the scheduling system from a hospital and physician standpoint. We apologize in advance for any significant inconveniences for you or your family. However, these inefficiencies are necessary to maintain many other schedules

Your surgery is scheduled for a specific time. We typically ask patients to be prepared to spend most of the day at the hospital.

Many potential obstacles exist that may prohibit a surgery from starting on time.

- Emergent surgeries scheduled by your surgeon or other surgeons that require utilization of operating rooms previously scheduled for elective cases.
- Difficulties in getting procedures started due to unforeseen issues of the anesthesia department, operating room staff, or hospital.
- Patients unable to arrive at the hospital on time.
- Cases scheduled prior to your case may be prolonged unexpectedly.
- Operative or anesthetic times are estimated and are occasionally longer than anticipated.
- Your surgeon may be on call for emergencies at another hospital and be required to leave unexpectedly.

Every effort is made by your surgeon, hospital and hospital staff to remain on schedule.

Due to the nature of the operating rooms, surgeons may have many patients on the same day in order to maximize efficiency. There are multiple surgeons in the operating room each day. Many of these surgeons have office responsibilities after leaving the operating room. By having multiple patients ready to go at the outset of the day, this helps to keep the operating room moving and ultimately saves time for many patients both in the OR as well as for the office appointments of these physicians.

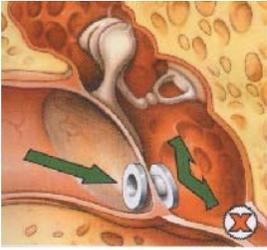
Thank you for your understanding,

Hugh M. Sims, MD
Brad Morris, MD

Parental Guide to Ear Tubes

What are ear tubes?

Ear tubes are tiny cylinders placed through the ear drum (tympanic membrane) to allow air into the middle ear. They also may be called tympanostomy tubes, myringotomy tubes, ventilation tubes, or PE (pressure equalization) tubes. These tubes can be made out of plastic, metal, or Teflon and may have a coating intended to reduce the possibility of infection. There are two basic types of ear tubes: short-term and long-term. Short-term tubes are smaller and typically stay in place for six months to a year before falling out on their own. Long-term tubes are larger and have flanges that secure them in place for a longer period of time. Long term tubes may fall out on their own, but removal by an otolaryngologist is often necessary.



Who needs ear tubes and why?

Ear tubes are often recommended when a person experiences repeated middle ear infection (acute otitis media) or has hearing loss caused by the persistent presence of middle ear fluid (otitis media with effusion). These conditions most commonly occur in children, but can also be present in teens and adults and can lead to speech and balance problems, hearing loss, or changes in the structure of the ear drum. Other less common conditions that may warrant the placement of ear tubes are malformation of the ear drum or Eustachian tube, Down Syndrome, cleft palate, and barotrauma (injury to the middle ear caused by a reduction of air pressure), usually seen with altitude changes such as flying and scuba diving.

Each year, more than half a million ear tube surgeries are performed on children, making it the most common childhood surgery performed with anesthesia. The average age of ear tube insertion is one to three years old. Inserting ear tubes may:

- reduce the risk of future ear infection,
- restore hearing loss caused by middle ear fluid,
- improve speech problems and balance problems, and
- improve behavior and sleep problems caused by chronic ear infections.

What happens during surgery?

A light general anesthetic (laughing gas) is administered for young children. Some older children and adults may be able to tolerate the procedure without anesthetic. A myringotomy is performed and the fluid behind the ear drum (in the middle ear space) is suctioned out. The ear tube is then placed in the hole. Ear drops may be administered after the ear tube is placed and may be necessary for a few days. The procedure usually lasts less than 15 minutes and patients awaken quickly. Sometimes the otolaryngologist will recommend removal of the adenoid tissue (lymph tissue located in the upper airway behind the nose) when ear tubes are placed. This is often considered when a repeat tube insertion is necessary. Current research indicates that removing adenoid tissue concurrent with placement of ear tubes can reduce the risk of recurrent ear infection and the need for repeat surgery.

Tubes

Your child has just had tubes placed in the eardrums. This instruction sheet is provided to help answer the most common questions about a child's care after tubes. The staff at ENT Bowling Green is always available to help you care for your child. If you have any questions, please do not hesitate to contact us.

What should I do if my child is bleeding from the ears?

Occasionally children will have very minor bleeding from their ears after tubes. If more than a few drops come out, or if the bleeding persists for more than a day or so, give us a call.

What if my child vomits after the surgery?

While it is unusual for a child to vomit after tubes, it can occasionally occur, generally as a side effect of the anesthetics used. It is very unusual for the vomiting to continue. If it does, give us a call.

Will my child's ears hurt after the surgery?

Children generally feel much better with their ears after tubes, but some will complain of pain after the surgery. This can be treated with Tylenol or Ibuprofen and should stop after a day.

Is it normal for my child to run a temperature?

Most children do not run fevers after tubes. Occasionally, a child will have a low-grade fever for a day or so after the surgery. If the fever persists, give your doctor a call.

Should my child be on antibiotics?

If your child was on antibiotics before the tubes were placed, it is a good idea to finish the prescription. Most children will be placed on antibiotic drops after surgery. These are used for a number of reasons: 1) to help keep the tubes from clogging 2) to treat any infection present at the time of surgery. Occasionally, children will also be placed on oral antibiotics. Prescriptions or samples will be provided to you at the time of surgery.

What about drainage from the ears?

Children with longstanding ear infections before the surgery may well have drainage from the ears for several days after the surgery. This is infection and fluid from the middle ear that will stop as the infection resolves. Antibiotic drops may be prescribed to help treat the drainage. If drainage persists beyond five days, please give us a call. Children in daycare may experience higher rates of drainage.

How long will it take my child to recover from the surgery and return to normal activities?

A child will quickly recover from surgery for tubes. This is because the anesthetic exposure is so brief and the surgery is minimally invasive. Most children will be back to normal within a few hours after the surgery. Occasionally, the afternoon nap will be a little longer than normal for the first day. A child should be able to return to his or her normal activities the next day.

What should my child eat and drink after the surgery?

The first sips after the surgery should be of clear liquids, such as water or juice. The child should rapidly progress to eating a regular diet.

Why does my child tug at the ears after the surgery?

It is not uncommon for a young child to tug or pull at the ears after surgery. We think that this is because they are so accustomed to feeling fullness in the ears from the fluid, that once the fluid is drained the ears feel odd. Young children in particular cannot express this verbally, so they pull or tug at the ears for several days until they get use to the feeling of having normal ears. Older children tell us that they cannot feel the tubes in their ears.

Can my child hurt the tubes by sticking a finger in the ear canal?

No, the tubes are further down in the ear canal than the child can reach.

Will vigorous physical activity cause the tubes to come out?

No, your child can jump and run and bounce without fear that the tubes will come out.

What about flying?

Your child will do fine with flying as the tubes will allow the pressure in the ears to equalize easily.

What about keeping water out of my child's ears?

ENT doctors have different opinions as to whether you should keep water out of your child's ears after surgery. Some studies conclude that the risk of infection is increased and other studies report no difference between children with or without water protection. We suggest that you keep all dirty water out of your child's ears after tubes have been placed. This includes lakes, streams, creeks as well as bath water. Children should not place their ears under any dirty water. If children are swimming and are planning to go under water (deeper than 2 feet), they should be fitted with earplugs and an Ear Band-It or swimming cap. For younger children that are primarily surface swimming and splashing, plugs are not as necessary. Custom fitted plugs and Ear Band-Its are available at the office as well as local home health care facilities.

Getting water in your child's ears once or twice is not a disaster. What you should try to avoid is chronic water exposure, as this can lead to infection and drainage from the tubes. Although this drainage can be treated with oral antibiotics or drops, we hope to avoid this,

as one of the reasons your child had tubes placed in the first place was to try to reduce the amount of antibiotic administered.

Your child will need a checkup in two or three weeks to make sure everything is all right and to answer any of your questions. If things go as planned, your child will be seen every six months after surgery until the tubes are out. Most tubes will fall out without intervention. If tubes are still present 24-36 months (depending on the age of the patient) after placement, surgical excision may be required.

If you see drainage out of your child's ears, notify the office. If another physician starts treatment of an ear infection, notify the office for further instructions regarding evaluation.

Adenoidectomy Information

Indications:

Adenoidectomy may be recommended when:

- [Enlarged adenoids](#) are blocking the airway, which may be suspected if the child:
 - Has enlarged adenoids
 - Snores excessively
 - Has [trouble breathing](#) through the nose ([nasal obstruction](#))
 - Has episodes of not breathing during sleep ([sleep apnea](#))
 - Has orofacial or dental growth problems

Adenoidectomy may be recommended if the child has [chronic ear infections](#) that:

- Interfere with child's education
- Persist despite antibiotic treatment
- Recur 5 or more times in a year
- Recur 3 or more times a year during a 2-year period

Adenoidectomy may be recommended if the child has [chronic](#) or repeated bouts of [tonsillitis](#).

The adenoids normally shrink as the child reaches adolescence and adenoidectomy is rarely needed after reaching the teenage years.

Adenoidectomy is the surgical procedure in which the adenoids are removed. Adenoids are lymphoid tissue located in the back of the nose. They often are not understood by the lay public or by physicians who are not otolaryngologists because they are not observed during routine physical examinations because of their location. Although the tissue composition of adenoids is the same as that of the tonsils, the diseases associated with infected adenoids differ from the diseases associated with infected tonsils, based on their location. This causes additional confusion because the adenoids are often simultaneously grouped with the tonsils.

Adenoids are on the posterior nasopharyngeal wall posterior to the nasal cavity. They are a component of the Waldeyer ring of lymphoid tissue, which is a ring of lymphoid tissue in the oropharynx and nasopharynx that consists mainly of the adenoids, the palatine tonsils, and the lingual tonsils.

Adenoids are present at birth and then begin to enlarge. They, along with the tonsils, continue to grow until individuals are aged 5-7 years. The adenoids usually become symptomatic, with snoring, nasal airway obstruction, and obstructed breathing during sleep, when children are aged approximately 18-24 months. Children in daycare or children with allergies may become symptomatic earlier. By the time children reach school age, the adenoids normally begin to shrink, and, by the time children reach preteen or teenage years, the adenoids are usually small enough for the child to become asymptomatic.

Recurrent or persistent middle ear effusion

Recurrent or persistent otitis media is multifactorial and age-dependent. The 2 main features accounting for disease in the middle ear are immune function and the function of the eustachian tube. Infants have a natural lack of immune function and poorer eustachian tube function, both of which improve over time. Many children outgrow their ear infections because of this maturity. Persistent ear infections or fluid problems in children are usually related to persistent immature eustachian tube function, dysfunction related to chronic adenoid infection, or dysfunction of the eustachian tube related to congestion from allergic rhinitis. Several studies indicate that eustachian tube function is improved and fluid collection is prevented following adenoidectomy, independent of the size of the adenoids.

Chronic sinusitis

For patients with chronic sinusitis, the adenoid appears to act as a reservoir of infection. This is based on the improvement observed following adenoidectomy independent of the weight of the adenoids in children with symptoms of chronic sinusitis.

Nasal airway obstruction

Enlarged adenoids can also cause nasal airway obstruction, with clinical symptoms of nasal congestion, snoring, and breathing through the mouth, by physically blocking the back of the nose. Symptoms of nasal airway obstruction may overlap with chronic sinusitis symptoms, and the physical obstruction may add to sinusitis itself by blocking normal nasal flow posteriorly, resulting in a stasis of secretions and an obstruction in the sinus outflow tract.

Often, enlarged adenoids (with the tonsils) can obstruct breathing patterns in children and can cause obstructive breathing, including apneas, at night. Obstruction is based on their size alone. However, when enlarged, the adenoids may have a chronic infection.

Dental and Orofacial growth problems

Enlarged adenoids may cause problems with dental or orofacial growth of some patients. If this is suspected adenoidectomy may be removed to assist with palatal growth or other facial bone growth patterns.

If we can help you at all, please do not hesitate to contact us.

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