

How ear infections are treated



Treatment starts with assessment and pain relief

For a baby, treatment begins with confirming the most likely problem. Acute otitis media means inflammation and infected fluid in the middle ear, usually after a viral upper respiratory infection. Otitis media with effusion means fluid remains behind the eardrum without the same signs of acute infection. Otitis externa, or swimmer's ear, affects the ear canal and is treated differently. Because symptoms overlap, a clinician uses the history and an ear exam, often with an otoscope, to look for eardrum bulging, redness, impaired mobility, fluid, or drainage.

Pain control is central. Ear pressure can hurt intensely, and antibiotics, when used, do not relieve pain immediately. Clinicians commonly discuss age-appropriate acetaminophen or ibuprofen, with dosing based on the baby's current weight and medical history. Aspirin is avoided in children. Some clinicians may consider anesthetic ear drops for short-term pain relief, but only when the eardrum is intact and the drops are appropriate for the child. Ear drainage warning signs matter because drainage may indicate a perforated eardrum or another diagnosis that changes treatment.

Observation versus antibiotics

Not every middle-ear infection needs immediate antibiotics. In selected children with mild symptoms, clinicians may recommend observation, sometimes called watchful waiting, because many acute ear infections improve as the immune system clears the infection. This approach is only reasonable when the child is old enough for it to be considered, symptoms are not severe, follow-up is dependable, and caregivers understand what changes should trigger re-evaluation.

Age is a major factor. Babies younger than 6 months are usually treated more cautiously, and clinicians generally have a lower threshold for in-person assessment and antibiotics. For children 6 to 23 months, bilateral acute otitis media or more intense symptoms often pushes the decision toward antibiotics. In older toddlers and children with mild pain, lower fever, and symptoms for less than about 48 hours, observation may be discussed.

Observation is not the same as doing nothing. It means active comfort care, monitoring hydration and behavior, and having a clear plan for what to do if pain, fever, sleep disruption, or feeding worsens. Families should know whom to call, when to return, and whether a delayed prescription has been provided.

When antibiotics are recommended

Antibiotics are more likely when a baby is very young, symptoms are moderate to severe, fever is higher, ear pain has persisted, both ears are infected in a younger child, or fluid is draining from the ear. They may also be chosen when follow-up is uncertain or when the child has medical factors that increase risk. The goal is to treat likely bacterial acute otitis media while avoiding unnecessary antibiotic exposure when the infection is likely to resolve without it.

When an antibiotic is indicated, many guidelines identify amoxicillin as a common first-line option for uncomplicated acute otitis media, unless allergy, recent amoxicillin use, concurrent purulent conjunctivitis, or other clinical factors suggest another choice. A clinician may choose amoxicillin-clavulanate or another agent in specific circumstances. The exact medication, dose, and duration should come from the child's clinician, because age, weight, allergy history, local resistance patterns, and recent antibiotic exposure all matter.

Caregivers should not use leftover antibiotics, share another child's prescription, or stop a prescribed course early without medical advice. If symptoms fail to improve or worsen after 48 to 72 hours of appropriate treatment, the child should be rechecked because the diagnosis, medication choice, complications, or adherence issues may need reassessment.

Comfort care at home

Supportive care can make a meaningful difference while the infection runs its course or while antibiotics begin to work. Offer fluids or feeds frequently, because babies with fever or pain may take smaller volumes. Holding the baby upright during waking comfort periods may ease pressure for some children, although sleep positioning should still follow safe sleep guidance. A warm compress held gently against the outside of the ear may be soothing if the baby tolerates it.

Fever management should be individualized. Fever in young babies deserves particular caution because age changes the urgency of evaluation. Newborn fever warning signs, such as a rectal temperature of 100.4 F or higher in a baby under 3 months, should prompt urgent medical advice. For infants, ask your clinician which measurement site to use; rectal temperature in babies is often treated as the closest estimate of core temperature, but technique and age matter.

Medication safety is part of treatment, not an afterthought. Use weight-based dosing guidance from the pediatrician, pharmacist, or product label, and avoid combining products that contain the same active ingredient unless a clinician specifically advises it. Do not put cotton swabs, oils, herbal drops, or unapproved remedies into the ear canal. Safe outer-ear cleaning is limited to what you can see externally, and baby ear canal safety means leaving the canal and eardrum assessment to trained clinicians.

Follow-up and persistent fluid

Many babies feel better within a few days, but middle-ear fluid can persist after pain and fever resolve. This residual fluid, called otitis media with effusion, may cause temporary muffled hearing, popping sensations, balance

changes, or sleep disruption. It does not always mean active bacterial infection, and repeated antibiotics are not usually helpful for simple persistent fluid without acute infection signs.

Follow-up is especially important if a baby continues to seem uncomfortable, is not feeding well, has ongoing fever, has new drainage, or does not improve as expected. A clinician may re-examine the ear to see whether the eardrum remains bulging, whether fluid is resolving, or whether another condition is present. If fluid lasts for months, if hearing seems reduced, or if speech and language development are a concern, hearing testing or referral may be appropriate.

Caregivers should also watch the area behind the ear. Swelling, redness, tenderness over the mastoid bone, protrusion of the ear, severe headache, stiff neck, unusual sleepiness, or neurologic symptoms are not typical uncomplicated ear infection symptoms and need urgent medical evaluation.

Recurrent infections and ear tubes

Some babies and toddlers have recurrent acute otitis media, especially during seasons with frequent respiratory viruses or in group childcare settings. Recurrent infections are usually defined by a pattern such as three episodes in about six months or four episodes in a year with at least one recent episode, though the final interpretation depends on documented exams and the child's overall health. In these situations, the pediatrician may discuss prevention strategies, hearing monitoring, and whether referral to an ear, nose, and throat specialist is appropriate.

Tympanostomy tubes may be considered for some children with recurrent infections, particularly when middle-ear fluid is present at evaluation or when infections are affecting hearing, sleep, antibiotic exposure, or quality of life. Tubes are tiny ventilating cylinders placed through the eardrum by a specialist to help air enter the middle ear and fluid drain. They do not prevent every illness, and they are not the right choice for every child, so benefits and risks should be reviewed carefully.

Risk reduction can support treatment plans but cannot replace care for an active infection. Keeping routine vaccinations current, reducing tobacco smoke exposure, practicing respiratory hygiene, and breastfeeding when possible may

lower risk for some children. The practical goal is not perfection; it is fewer infections, prompt comfort, and timely medical decisions when symptoms return.