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LETTER TO THE EDITOR

Elderly but could be mastoiditis?

Yaşlı, ama mastoidit olmasın?

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To the Editor**,**

Mastoiditis is a condition that can occur two weeks after the onset of acute suppurative otitis media. Two weeks after the onset of acute suppurative otitis media, mastoiditis may occur. Disruption of the drainage of mastoid cells is the primary physiopathological mechanism causing mastoiditis[1]. The majority of patients with acute mastoiditis are children, and the clinical findings of retroauricular erythema and fluctuation, as well as auricular proptosis, can be used to detect symptoms of persistent otalgia, fever, and malnutrition[1,2]. By analyzing the elderly patient with mastoiditis in our clinic, this case study aims to highlight the significance of the topic.

With the support of her daughter, an 86-year-old female patient was admitted to the family medicine outpatient clinic with complaints of fatigue and urinary incontinence. He and his daughter helped in gathering the patient's medical history.

The patient who submitted an application complaining of weakness stated that it had been bothering her for three days and that he was constantly exhausted. In addition to the weakness, she claimed that she had nausea but no vomiting. No stomach discomfort, no fever, no sweats at night. She was reported to not eating very well because of a decreased appetite and to have hearing loss as a result of aging.

When her resume was examined, it was observed that she had been treated for hypertension with a combination of angiotensin II receptor antagonist and hydrochlorothiazide, hadn't been reported an accident and/or undergone surgery, and was living with her daughter.

Her physical examination revealed that she was in generally good health, with measurements of her body temperature (36.7 ^{o}C), pulse (75 beats per minute), and respiratory rate (16 breaths per minute).

The patient was referred for additional testing and ear nose throat (ENT) evaluation on the grounds that mastoiditis might be present despite the patient's otoscopic examination findings being deemed normal. As a result of the computerised tomography (CT) results, antibiotic therapy was started.

According to the cranial CT report: ” the fourth ventricle is located in the posterior fossa and is in its normal form. Densities in the cerebellar hemispheres are normal. Cisterns in pontus are open. The midline is in a normal position in the supratentorial region. The perimesencephalic and suprasellar cisterns are accessible. Symmetrical cavernous sinuses exist. Vascular structures at the polygon level have a natural width. The shape and size of the ventricular system are both normal. Densities in the cerebral hemispheres are normal. The basal ganglia showed no pathology. Convexity sulci and Sylvian fissures are open. There was no evidence supporting a vascular pathology or a space-occupying lesion. Bone contours in the skull are regular. Middle ear aeration and left temporal bone mastoid cell disappeared. acceptable for otitis and mastoiditis.”

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According to most estimates, the incidence among adults and the elderly is around 0.25%. However, according to other studies, the number could reach 9%. According to estimates, after impacted cerumen, chronic suppurative otitis media is the second most common ear condition affecting elderly people. According to reports, complications with the middle ear, particularly in children, claim the lives of 33 out of every 10 million patients[3].

Management of acute mastoids continues to be debatable. Institutional policies or the preferences of the treating physician or surgeon are frequently used to guide treatment. Inpatient intravenous antibiotics with adequate blood-brain barrier penetration and activity against S. pneumoniae, multidrug resistant S. pneumoniae, and H. influenza are generally required for the treatment of acute mastoiditis secondary to acute otitis media (AOM)[4,5]. Antibiotics should also be used to treat Gram-negative aerobes, Pseudomonas spp., methicillin-resistant S. aureus, and S. aureus if Acute Mastoidits cases are secondary to chronic suppurative otitis media (CSOM) without cholesteatoma[4,6].

Kaufman reported in their review that the effectiveness of mastoiditis treatment as measured by complications at hospital discharge and during postdischarge follow-up. Lateral sinus thromboses (LST), intracranial abscesses (IA), and meningitis were intracranial complications (ICCs). A common intratemporal complications (IT) was subperiosteal or retroauricular abscesses (SPA). Extracranial complications (ECCs) outnumbered ICCs by a factor of more than two. SPA was the most typical overall complication. However, a previous study looking at patients with intracranial complications showed that many patients presented without symptoms of otorrhea or subperiosteal abscess. Mastoiditis may frequently involve concurrent involvement of local anatomic structures leading to extracranial manifestations before development of intracranial complications[2,7].

Acute mastoiditis cannot be prevented by antibiotics, and the emergence of infectious complications is not always caused by pathogens that are resistant to treatment. Maintaining a high degree of suspicion for potential intratemporal and intracranial complications brought on by AOM is essential. Acute mastoiditis may be the first sign of ear disease in very young children. Although the clinical diagnosis of acute mastoiditis persists, subsequent CT scans distinguish between periostitis and the development of subperiosteal abscesses and show concurrent infectious complications. The preferred course of treatment is still surgical drainage combined with intravenous antibiotics[6].

Otitis media can affect elderly people, despite the fact that it is typically thought to affect children. Although the prevalence of otitis media in the elderly population varies between nations, it is typically low, with a range of 0.25–9%. However, harmful side effects can develop. Otitis media can manifest in a variety of ways in the elderly, including otitis media with effusion, suppurative otitis media, and mastoiditis.

Otalgia may occur in elderly patients along with or without hearing loss or other symptoms. Mastoiditis, petrositis, and labyrinthitis can all be brought on by infection through nearby structures. More severe effects include facial nerve palsy, meningitis, subarachnoid/subdural abscesses, encephalitis, brain abscesses, lateral/sigmoid venous sinus thrombosis, and hydrocephalus. The family physicians should identify such a situation as soon as possible because it can develop subtly, especially in the primary care setting. Adequate and appropriate treatment of otitis and any suspected infections should be the basic approach, and strict control of risk factors that may lead to complications is necessary.

The consent has been taken from the patient to publish the data.

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