NM Northwestern Medicine

See adsp.nm.org for more information

Acute Pharyngitis

OUTPATIENT STEWARDSHIP TIP SHEET

Viral pathogens account for majority of cases in adults and pediatrics. Infrequently caused by bacterial pathogens such as **Group A *Streptococcus*** (≤10% in adults, ≤25% in pediatric patients)

Goal: Avoid unnecessary antibiotics & identify bacterial cases caused by Group A *Streptococcus* (GAS)

	Viral	Bacterial (GAS)
Symptoms & Clinical Findings	**Cough** Fever (maybe) Rhinorrhea Conjunctivitis Oral ulcers Hoarseness Viral exanthem Diarrhea	**Lack of Cough** Sudden sore throat Fever Headache Nausea/Vomiting Sandpaper rash Purulent tonsillar exudates Tonsillar erythema/edema Tender cervical lymphadenopathy Recent exposure to GAS pharyngitis
Diagnosis	GAS Rapid Antigen Diagnostic Testing (RADT) should be performed on all patients >3 years old **without** clear signs of viral etiology • **RADT is not recommended in patients with symptoms highly suggestive of viral etiology** • Adults do not require throat culture for confirmation of negative RADT due to low prevalence of GAS • Children <3 years do not require testing due to low prevalence of GAS & rare incidence of rheumatic fever • In cases of negative RADT among children 3 to 15 years old, send throat culture for confirmation Consider SARS-CoV-2 PCR testing (refer to adsp.nm.org for treatment guidelines if positive)	
Treatment	**Adjunctive Measures Only (as below)** No antibiotics	**Adult & Adolescent** **Standard Antibiotics:** **Amoxicillin** 500 mg BID OR 1000 mg daily for **10 days** OR **Penicillin VK** 500 mg TID for **10 days** **Penicillin Allergy History (see NM O/P Allergy Risk Assessment first):** **Low Risk Beta-lactam Allergy Hx:** **Cephalexin** 500 mg BID for **10 days** **Moderate Risk:** **Cefuroxime^** 250 mg BID for **10 days** ^ dissimilar drug structure from penicillins **High Risk Beta-lactam Allergy Hx:** **Azithromycin** 500 mg QD for **1 day**, then 250 mg QD for **4 days**
		Pediatric **Standard Antibiotics:** **Amoxicillin** 50 mg/kg daily for **10 days** (maximum dose: 1000 mg/day) **OR** **Penicillin** • <27 kg: 250 mg TID for **10 days** • ≥27 kg: 500 mg TID for **10 days** **Penicillin Allergy History (see NM O/P Allergy Risk Assessment first):** **Low Risk: Cephalexin** 20 mg/kg per dose BID for **10 days** (maximum dose: 1000 mg/day) **Moderate Risk: Cefixime^** 4 mg/kg per dose BID for **10 days** (maximum dose: 400 mg/day) OR **Cefpodoxime^ OR Cefuroxime^ (use doses from pediatric pneumonia 1-pager)** **High Risk Beta-lactam Allergy Hx:** **Azithromycin** 12 mg/kg daily for **5 days** (maximum dose: 500 mg/day)
Adjunctive Measures	Increase fluid intake Antipyretics/Pain relief (Acetaminophen, Ibuprofen) Lozenges/topical analgesics Gargle with warm salt water: 1/4 teaspoon of salt in 8 ounces of water	

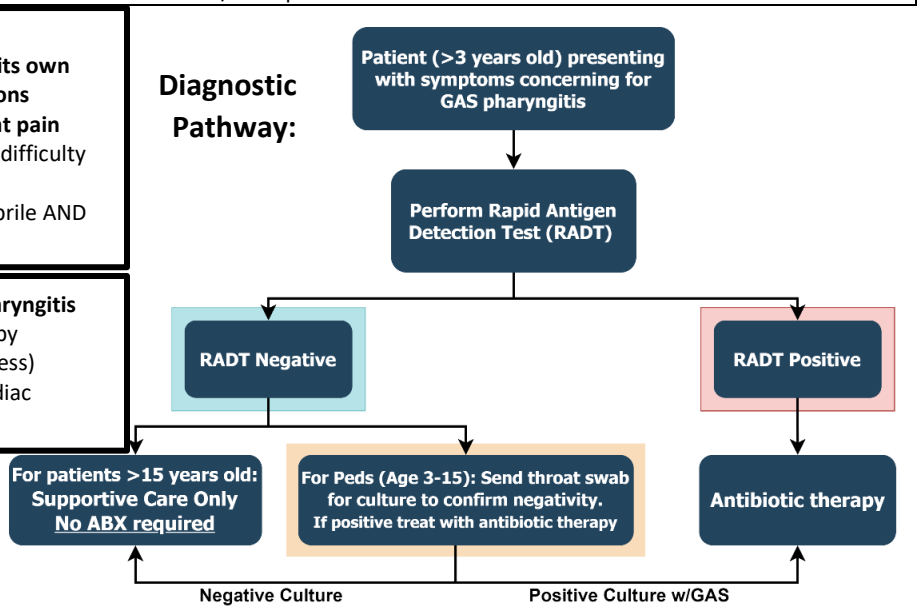
Key Points for Counseling Patients

1. A virus won't respond to antibiotics and will improve on its own
2. Antibiotics may do more harm than good for viral infections
3. Use of gargling/analgesics/antipyretics help reduce throat pain
4. Seek additional care if dehydration, difficulty breathing or difficulty swallowing arise
5. If GAS is present, stay home from work or school until afebrile AND ≥12 hours into antibiotic therapy

When to Consider Further Evaluation in Confirmed GAS Pharyngitis

1. No clinical improvement after 72 hours of antibiotic therapy
2. Concern for suppurative complications (e.g., tonsillar abscess)
3. After GAS pharyngitis, concern for arthritis, carditis or cardiac valvular disease

Diagnostic Pathway:



ADSP Northwestern Medicine Antimicrobial and Diagnostic Stewardship Program

Updated 10 18 2023