Sore Throat

Differential diagnosis:

Simple URTI

- Viral/Bacterial – Pharyngitis, Tonsillitis, or Pharyngotonsillitis

Other acute infections

- Glandular fever
- Epiglottitis/Tracheitis
- Diphtheria

Abscess

- Peritonsillar - Quinsy
- Retropharyngeal abscess

Foreign body

Toxic ingestion

Investigations

Not routinely. See below.

- Rapid antigen testing (ASOT)
  - High specificity, but most only 80% sensitive
  - Not available currently and no evidence it improves management
- Throat swab culture
  - 90-95% sensitive
  - Up to 40% GABHS carriers → culture positive but ASOT neg
  - May consider if not sure whether to treat as bacterial
  - If culture positive then twice as likely to have symptomatic benefit from ABx
- ASOT & Monospot/EBV serology - Only if likely or lasted>10d
- UEC - If dehydration
- FBC & bld culture - If toxic. EBV may show lymphocytosis instead of neutrophilia
- Blood culture - If toxic.

Viral vs Bacterial Pharyngotonsillitis

Feature that support viral:

- Conjunctivitis, coryza, cough, vesicles/ulceration, age<=3
- EBV – tonsillar hypertrophy, thick exudate, teenage, post-ABx rash

Features pro bacterial (usually GABHS, also Hib, Staph, pneumococcus, occ Arcanobacterium hemolyticum in adolescents)

- Typical features of scarlet fever
- Modified Centor score:
  - Consider 5 features: Fever, tender anterior cervical LN, tonsil swelling/exudate, no cough (1 point for each) and age (+1 if aged 3-14y, -1 if >44y)

Score	Risk of GABHS	Plan
≤0	1-2.5% (~1%)	No test, no ABx
1	5-10% (~7.5%)	No test, no ABx
2	11-17% (~15%)	Test
3	28-35% (~30%)	Test
≥4	51-53% (~50%)	No test, give ABx

- The risk increases with local population prevalence of GABHS
- In schoolchildren may be 20%, higher in the indigenous pop

Management

- Analgesia
  - **Paracetamol** 15mg/kg q4h PO or PR
  - **Ibuprofen** 10mg/kg qid PO
  - **2% Xylocaine viscous** max 0.15ml/kg q2h Top – if not drinking/eating.
- Fluids: Oral if possible otherwise IVF
- Steroids: **dexamethasone** 0.15mg/kg PO/IV sometimes used if tonsils swollen+
- Antibiotics: Not routinely. Shortens symptoms by <24hrs. However may ↓Cx.
  - Only consider if likely bacterial, indigenous, toxic or immunosuppressed.
    - **Penicillin** 10mg/kg bd PO x 10d first line
    - Macrolide e.g. **roxithromycin** , **erythromycin** , **clarithromycin**, if penicillin allergic or not improving (could be *A. hemolyticum* in adolescent, if not viral)
    - If admitted for IV: **benzylpenicillin** 30mg/kg qid IV
- Disposition
  - Further review if toxic or Dx other than simple URTI
  - Discharge if not toxic and tolerating fluids, else admit for IVF or IV antibiotics

Complications

- Rheumatic Fever: <2% if untreated for 9d. More likely in Indigenous. ABx ↓risk by >66%
- Glomeronephritis: Inconclusive evidence to say if ABx are protective
- Suppurative: OM, Sinusitis, Abscess (~2% quinsy or retropharyngeal if untreated)
- Recurrence: Referral for tonsillectomy if >5 episodes/yr or Hx sleep apnoea
- Tosilloliths, Tonsil cyst or haemorrhage
- Guttate psoriasis

Tonsillectomy Indications

- Recurrent tonsillitis
  - 6 attacks in one year
  - 4-5 attacks per year for 2 years
  - 3 attacks per year for 3 years
  - Consider severity of attacks, response to Rx, Cx of episodes, general health
- OSA
- Suspected malignancy- unilateral enlargement