DST-205 Pharyngitis (Sore Throat): Adult

DEFINITION

Inflammation or infection of the mucus membranes of the pharynx. It may also affect the palatine tonsils.

POTENTIAL CAUSES

Infectious

Viruses

- Adenovirus
- Influenza
- Parainfluenza virus
- Epstein-Barr
- Coronavirus
- Rhinovirus
- Enterovirus
- Respiratory synctial virus
- Metapneumovirus
- Herpes simplex virus

Bacterial

- Group A beta-haemolytic strep
- Group C and G streptococci
- Chlamydia pneumoniae
- Diphtheria
- Mycoplasma pneumonia
- *Neisseria gonorrhea* or *chlamydia trachomatis (*related to sexual activity)

Fungi

- *Candida albicans* (immunocompromised)

Non-infectious

- Allergic rhinitis
- Sinusitis with post nasal drip
- Mouth breathing
- Trauma
- GERD (gastroesophageal reflux disease)

PREDISPOSING RISK FACTORS

- Previous episodes of pharyngitis or tonsillitis
- Smoking, exposure to cigarette smoke
- Overcrowding
- Immunocompromised
- Steroids, oral or inhaled
- Diabetes mellitus
- Oral sex

TYPICAL FINDINGS OF PHARYNGITIS

Note: Always consider the potential for epiglottitis and airway obstruction when a severely sore throat is out of proportion to the findings of the oropharyngeal exam.

Bacterial

History

- Abrupt onset of sore throat
- Pain with swallowing
- Absence of cough
- Fever or chills
- Malaise
- Headache
- Anorexia
- May have nausea, vomiting and abdominal pain

Physical Assessment

- Fever
- Pulse elevated
- Client appears ill
- Posterior pharynx red and edematous
- Tonsils enlarged, may be asymmetric
- Purulent exudate may be present
- Tonsillar and anterior cervical nodes may be enlarged and tender
- Erythematous "sandpaper" rash of scarlet fever (may be present with streptococcal infection)
- Liver/spleen enlargement +/- tenderness (e.g., mononucleosis)

Viral

History

- Slow progressive onset of sore throat
- Mild malaise
- Cough
- Nasal congestion

Physical Assessment

- Temperature elevated
- Posterior pharynx red and swollen
- Purulent exudate may be present
- Tonsillar and anterior cervical nodes may be enlarged and tender
- Petechiae or purple colour on palate (mononucleosis)
- Vesicles (if herpes)

Non-infectious

- Slow progressive onset of sore throat
- Mild malaise
- Cough
- Persistent, recurrent

- Pain on swallowing
- Posterior pharynx red and swollen
- Tonsillar and anterior cervical nodes may be enlarged and tender
- Exudate may be present

  Note: It is often impossible to distinguish clinically between bacterial and viral pharyngitis. Most pharyngitis is due to viruses (up to 90% in the adult population) and does not require treatment with antibiotics. For this reason it is important to utilize a sore throat score and diagnostic testing as available.

<table>
<tr><th colspan="2">Criteria</th><th>Points</th></tr>
<tr><td colspan="2">Temperature > 38’ Celsius</td><td>1</td></tr>
<tr><td colspan="2">Absence of cough</td><td>1</td></tr>
<tr><td colspan="2">Swollen, tender anterior cervical nodes</td><td>1</td></tr>
<tr><td colspan="2">Tonsillar swelling or exudates</td><td>1</td></tr>
<tr><td colspan="2">Age 3-14 years</td><td>1</td></tr>
<tr><td colspan="2">Age 15-44 years</td><td>0</td></tr>
<tr><td colspan="2">Age 45 years and over</td><td>-1</td></tr>
<tr><th>Total Score</th><th>Risk of Streptococcal infection (%)</th><th>Suggested Management</th></tr>
<tr><td>-1 to 1</td><td>1-10 %</td><td>No culture or antibiotic required</td></tr>
<tr><td>2-3</td><td>11-35%</td><td>Perform culture or rapid strep test. Treat only if test is +</td></tr>
<tr><td>4 or more</td><td>51-53%</td><td>Start antibiotic therapy if patient situation warrants (e.g., high fever or clinically unwell)

If culture or rapid strep test performed and negative, discontinue antibiotic</td></tr>
</table>

Note: Treatment with antibiotics may be warranted regardless of the score if there are concerns such as:

- household contact with streptococcal infection,
- a community epidemic of streptococcal infection,
- a client history of rheumatic fever, valvular heart disease, or immunosuppression, or
- a population in which rheumatic fever remains a problem

Geriatric considerations:

- Treatment may also be warranted if client is 65+ years with acute cough and 2 or more of the following criteria, or 80+ years with acute cough and one or more of:
  - Hospitalization in the past year
  - Diabetes Mellitus
  - Congestive Heart Failure
  - On glucocorticoids.

Diagnostic Tests

- Throat swab for culture and sensitivity (C&S)
- Rapid strep test (where available)

MANAGEMENT AND INTERVENTIONS

Goals of Treatment

- Eradicate infection
- Prevent complications
- Prevent spread of group A streptococcus

Non-pharmacologic interventions

- Bed rest during febrile phase
- Adequate oral intake of fluids
- Avoidance of irritants
- Gargling with warm saline (1 tsp. in 1 cup warm water)

Pharmacological Interventions

- Analgesics for mild to moderate pain:
  - acetaminophen 325mg, 1-2 tabs po q4-6h prn, or
  - ibuprofen 200mg, 1-2 tabs po q4-6h prn
- Treat with oral antibiotics if streptococcal infection is suspected:
  - Penicillin VK 600 mg po bid or 300 mg po tid for 10 days
- For clients with penicillin allergy or requiring a suspension (if pen V suspension not available):
  - Cephalexin 500 mg po BID for 10 days (DO NOT USE IF CLIENT HAS A SEVERE ANAPHYLACTIC REACTION TO PENICILLIN)

  OR

  - Azithromycin 500 mg po daily for 3 days

Pregnant and Breastfeeding Women

- Acetaminophen, penicillin VK, cephalexin and azithromycin may be used as listed above.
- DO NOT use ibuprofen in pregnant patients

If the infection has been determined to be due to chlamydia or gonorrhea, please refer to the appropriate STI DST.

POTENTIAL COMPLICATIONS

- Rheumatic fever (group A strep)
- Acute Glomerulonephritis (group A strep)
- Peritonsillar abscess
- Epiglottitis
- Retropharyngeal abscess
- Otitis media
- Sinusitis

CLIENT EDUCATION AND DISCHARGE INFORMATION

- Gargle frequently with warm salt water (1 tsp. in 1 cup warm water)
- Increase room humidity
- Eat soft bland foods

MONITORING AND FOLLOW UP

- Return to clinic if not improved in 24-48 hours

CONSULTATION AND/OR REFERRAL

- A consultation with a physician or nurse practitioner may be necessary if condition is recurrent or persistent or an undiagnosed underlying pathology is suspected.
- An immunocompromised client, or an unusual presentation of candidiasis, should be referred promptly to a physician or nurse practitioner.

DOCUMENTATION

- As per agency policy

REFERENCES

More recent editions of any of the items in the Reference List may have been published since this DST was published. If you have a newer version, please use it.

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