Tonsillitis and Sore Throat in Adults

Disclaimer

Contents

Background

About tonsillitis and sore throat in adults

- *Most cases are viral. Only a small number are caused by group A streptococcus (GAS) which is mostly seen in young adults aged < 25 years.*
- *Viral and bacterial causes cannot be reliably differentiated by clinical signs or symptoms, severity, or duration of illness.*

Red flags

- Peritonsillar abscess (quinsy) or haematoma
- Acute tonsillitis with airway obstruction or inability to tolerate oral intake
- Uncontrolled fever
- Post-operative tonsillar haemorrhage

Assessment

1. Examine patient for:
    - fever
    - abnormal appearance of tonsils and pharynx
    - cervical lymphadenopathy
    - systemic signs.

2. Consider ***criteria*** to help determine if patients have a group A streptococcus (GAS) infection and could benefit from antibiotic treatment.

Group A beta-haemolytic streptococcus (GABHS) infection criteria

Criteria	***Point***
Temperature > 38° C	*1*
No cough	*1*
Tender anterior cervical adenopathy	*1*
Tonsillar swelling or exudate	*1*
Age 3 to 14 years	*1*
Age 15 to 44 years	*0*
Age over 45 years	*-1*
Total Score:	

A score of 4 indicates a high likelihood of growing GABHS on throat swab.[1]
If the score is < 4, the chance of developing GABHS in < 4%, i.e., antibiotics are ***not*** *effective in 96% of cases.*

3. Do not perform routine throat swabs. Swabs are only recommended in those at high risk of rheumatic fever.

4. Consider whether patient is at ***risk of rheumatic fever***[2] and commence empiric, immediate antibiotic treatment until throat swab cultures are known.

Risk of rheumatic fever

- *Past history of rheumatic fever*
- *Lower socioeconomic status*
- *Overcrowded homes*
- *Aboriginal and Torres Strait Islander*

5. In young adults, consider ***infectious mononucleosis.***

Typical features of infectious mononucleosis

- *Malaise*
- *Fatigue*
- *Nausea*
- *Fever*
- *Pharyngitis (may present with milder disease without pharyngitis)*
- *Tonsillitis with white membrane*
- *Adenopathy*
- *Splenomegaly*
- *Hepatomegaly*
- *Jaundice*
- *Rash*

Management

Acute management

1. Arrange immediate ENT referral or admission if patient presents with any ***red flags.***

Red flags

- *Peritonsillar abscess (quinsy) or haematoma*
- *Acute tonsillitis with airway obstruction or inability to tolerate oral intake*
- *Uncontrolled fever*
- *Post-operative tonsillar haemorrhage*

2. Provide analgesia.

3. If suspected group A streptococcus infection, ***antibiotics*** are appropriate if patient:

Antibiotics

- *Phenoxymethylpenicillin (penicillin V) 500 mg, twice daily for 10 days is the drug of choice.*
- *Cephalexin 1 g, 12-hourly for 10 days is suitable for patients who are hypersensitive to penicillins (excluding immediate hypersensitivity).*
- *Azithromycin 500 mg daily for 5 days is suitable for patients with immediate hypersensitivity to penicillin.*
- *Do not use amoxicillin in case diagnosis is infectious mononucleosis, as a rash can develop.*
- *Antibiotics do prevent glomerulonephritis and rheumatic fever in susceptible patients.*

- has a history of rheumatic heart disease.
- is aged 2 to 25 years and lives in a community with high incidence of acute rheumatic fever (indigenous communities in central and northern areas of Australia, Maori and Pacific Islander people).
- has scarlet fever.
- is very unwell or with severe clinical features.

4. For very severe symptoms in adults such as drooling or difficulty swallowing, corticosteroids (prednisolone or dexamethasone) can be used in addition to antibiotics for two days.

5. Advise patient:
    - infection is self-limiting.
    - to rest, and time off study and work.

Recurrent tonsillitis

Management is determined by the frequency of episodes and the impact on day-to-day activities.

1. Assess and treat each acute episode as above. Preventative antibiotics are not advised.

2. Consider a referral for tonsillectomy if:
    - ≥ 4 episodes of acute tonsillitis in the preceding 12 months, or ≥ 6 episodes per year in the preceding two years.
    - absent from work or studies for ≥ 4 weeks in a year.
    - tonsillar concretions with halitosis.
    - suspicious unilateral solid tonsillar mass.

Referral

- Arrange immediate ENT referral or admission if patient presents with any ***red flags.***
- If ***tonsillectomy*** indicated, arrange urgent or routine ENT referral.

Tonsillectomy

Consider a referral for tonsillectomy if:

- *≥ 4 episodes of acute tonsillitis in the preceding 12 months, or ≥ 6 episodes per year in the preceding two years.*
- *absent from work or studies for ≥ 4 weeks in a year.*
- *tonsillar concretions with halitosis.*
- *suspicious unilateral solid tonsillar mass.*

- In all requests, include:
  - severity of episodes
  - time off studies or work
  - response to treatment
  - use of anticoagulant medication or family history of coagulation disorder.
  - symptoms of obstructive sleep apnoea (OSA).

Information

For health professionals

Further information

- Australian Family Physician – Rheumatic Fever: Identification, Management, and Secondary Prevention
- Cardiac Society of Australia and New Zealand – New Zealand Guidelines for Group A Streptococcal Sore Throat Management

For patients

- Australian Commission on Safety and Quality in Health Care – Sore Throat: Should I Take Antibiotics?
- Kids Health – Sore Throat: More Detail
- Patient – Tonsillitis

Sources

References

1. Mclsaac WJ, White D, Tannenbaum D, Low DE. A clinical score to reduce unnecessary antibiotic use in patients with sore throat. CMAJ. 1998;158(1):75-83.

2. New Zealand Guidelines Group. New Zealand Primary Care Handbook. 3rd ed. Wellington: Ministry of Health; 2012. p. 85-94. Chapter 9, Rheumatic fever and sore throat management.

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