TONSILLITIS in ADULTS

This Clinical Pathway does not include sore throat in those aged 15 and less, where Rheumatic Fever prevention is an issue.

Overview:

- 90% viruses and others
- 10% Group A streptococcus (GAS) … major treatable pathogen
- No reliable clinical indicators to differentiate GAS from other causes
- 3 of these 4 clinical indicators being present indicates a subgroup more likely to have GAS, treating these will still result in 50% over prescription of antibiotics.
    - Tonsillar exudates
    - Tender anterior cervical adenopathy
    - History of fever
    - Absence of cough
- Goals of treatment:
    - A slight reduction in the duration and severity of symptoms if begun early
        - Modest reduction, 1 to 2 days fewer symptoms at most
        - Increased risk of recurrence in those given antibiotics early
        - No risk in under treatment with antibiotics
    - Prevention of local suppurative complications (peritonsillar abscess)
        - Less common than a generation ago
    - Prevention of contagion
        - 35% transmission risk in family or school
        - Minimally contagious after 24 hours penicillin
    - Prevention of acute rheumatic fever
        - Very uncommon over 15yrs

Suggested approach based on the above:

- Treat the toxic or severely ill with all 4 clinical indicators immediately, take throat swab.
- Those less toxic and with 2 or more clinical indicators, take throat swab and await result before antibiotic prescription
- Patients who have frequent, recurrent, mild to moderate infections … delaying treatment for two or three days may allow the patient's natural immunity to develop while potentially sacrificing only a mild gain in symptom improvement.

Treatment:

- Oral Penicillin V 500mg tds or qid for 10 days
    - 50% relapse if stopped in 3/7, 34% in 6-7/7
    - Untreated, GAS eliminated naturally in 50% in 1/12
- Amoxycillin 500mg tds (or 750mg once daily) for 7/7

    - Amoxycillin / clavulanate should not be used as first-line therapy due to its broad spectrum of activity and expense. However, it may be useful in patients with recurrent GAS infection and when copathogens are colonizing the tonsillopharynx in a GAS-infected patient
- Macrolide antibiotic (eg erythromycin 800mg bd for 5/7) in penicillin allergic

Treatment Failure at 48 hours:

- Treatment may fail for many reasons
    - Not GAS as pathogen even if positive culture (ie carrier of GAS with other pathogen)
    - In severe infections penicillins and cephalosporins not as effective once bacterial multiplication rate reduces (Eagle effect)
    - Compliance or absorption problems.
- Seek evidence of bacterial infection
    - WBC
    - CRP and ESR
    - Check throat swab result
- If evidence of bacterial infection AND patient still toxic with all 4 clinical indicators
    - Consider rehydration with IV saline.
    - Switch penicillin antibiotics to cephalosporins
        - Eg: Cefaclor 250-500mg bd or Cephalexin 1g bd for 7 days
        - If oral tolerance a problem, give Cefazolin 2g BD for up to 3 days, 8 to 12 hours apart.
    - Consider discussion with clinician on call possibility of clindamycin or other antibiotic use.
    - A single IV injection of Dexamethasone 8-12mg (available on MPSO) should be given if IV antibiotics are administered, particularly if peri-tonsillar oedema causes difficulty swallowing. *Note IV Saline as above also strongly indicated in this situation.*
    - Consider admission if particularly ill or any suggestion of airway compromise.