Louth: Antimicrobial Guidelines - Louth Hospitals: Antimicrobial Guidelines: Ear Nose and Throat

Centor Score	Estimated Risk of GAS Pharyngitis
Score one point for each sign present: • Tonsillar exudate • Swollen tender anterior cervical nodes • Lack of cough • Fever	0 signs = 2.5% risk of GAS pharyngitis 1 sign = 6.5% risk of GAS pharyngitis 2 signs = 15% risk of GAS pharyngitis 3 signs = 32% risk of GAS pharyngitis 4 signs = 56% risk of GAS pharyngitis

Indication

Acute Sore Throat

First Line Antimicrobials

Mostly viral. Centor Score 3-4: Modest benefit of antimicrobials in symptom reduction. Watchful waiting/delayed prescription strategy (patient waits for 1-2 days and fills prescription if still not better by then or GAS cultured from swab) is a valid option.

Phenoxymethylpenicillin (Calvepen®) 666mg QDS PO

If unable to tolerate oral medications: Benzylpenicillin 1.2g QDS IV

Penicillin Hypersensitivity

As above, if antimicrobials indicated: Clarithromycin 500mg BD PO

N.B. Consider potential for drug interactions, e.g. statins, prolongation of QT interval

Comments

Sore throat should not be treated with antimicrobials to prevent development of rheumatic fever and acute glomerulonephritis in low-risk patients. The prevention of suppurative complications (quinsy, otitis media, cervical lymphadenitis, acute otitis media, mastoiditis or sinusitis) is not a specific indication for antimicrobial therapy in acute sore throat.

ALWAYS REVIEW empiric therapy in conjunction with C&S after 48 hours.

Microbiological Investigations:

- Throat swab not routinely necessary. If clinical diagnosis of GAS pharyngitis (Centor score 3–4), swab surface of both tonsils.
- Blood cultures if systemically unwell

Consider Corynebacterium diphtheriae – Droplet transmission, gradual onset sore throat, fever, exudative pharyngitis, which may progress within 3 days to thick grey pseudomembranes firmly attached to underlying mucosa – up to 20% mortality secondary to toxin effects – Check vaccination history and inform on-call Clinical Microbiologist immediately if suspected diphtheria http://www.hpsc.ie/A-Z/VaccinePreventable/Diphtheria/

Consider EBV infection in young adult with pharyngitis, fever, cervical adenopathy

- Check WCC differential for lymphocytosis
- Request peripheral blood smear for atypical lymphocytes
- Monospot test for heterophile antibodies – negative result does not rule out EBV infection
- EBV serology may be helpful if diagnostic uncertainty and high clinical suspicion
- Severe EBV infection associated with risk of subsequent secondary bacterial infection – counsel patient to report if new symptoms

Duration of Treatment

10 days

Indication

Peritonsillar Abscess (Quinsy)

- Localised deep neck infection between tonsil and its capsule
- Often polymicrobial; key pathogens include Group A Streptococcus, Fusobacterium spp. and Streptococcus milleri group

First Line Antimicrobials

Co-amoxiclav 1.2gm TDS IV

Empiric IV to PO switch: Co-amoxiclav 625mg TDS PO

NON-immediate-onset and NON-severe Penicillin Hypersensitivity

Cef-UR-oxime 1.5g TDS IV

AND

Metronidazole 400mg TDS PO (or 500mg TDS IV only where oral route is not feasible - excellent oral bioavailability)

Empiric IV to PO switch: Cefaclor LA 750mg BD PO **AND** Metronidazole 400mg TDS PO

IMMEDIATE-onset or SEVERE Penicillin Hypersensitivity

Clindamycin 450mg QDS PO or 600mg QDS IV (excellent oral bioavailability)

Comments

N.B. The primary treatment of an abscess is surgical drainage.

Risk factors for peritonsillar abscess include smoking, poor periodontal hygiene, male gender, prior antimicrobials, immunocompromise and ages 15 – 40 years.

Lemierre's syndrome is a rare complication arising after pharyngitis due to Fusobacterium necrophorum:

- Blood cultures positive for F. necrophorum
- Internal jugular vein thrombophlebitis
- Metastatic infection – lungs, deep neck space or other sites

ALWAYS REVIEW empiric therapy in conjunction with C&S after 48 hours.

Microbiological Investigations:

- If drainage or aspirate of abscess, send pus to microbiology laboratory
- Mycobacterial staining and TB culture may be indicated – discuss with Clinical Microbiologist
- Blood cultures if systemically unwell

Duration of Treatment

7 to 10 days. Ultimate duration dictated by clinical response and adequate source control (i.e. drainage of abscess).