

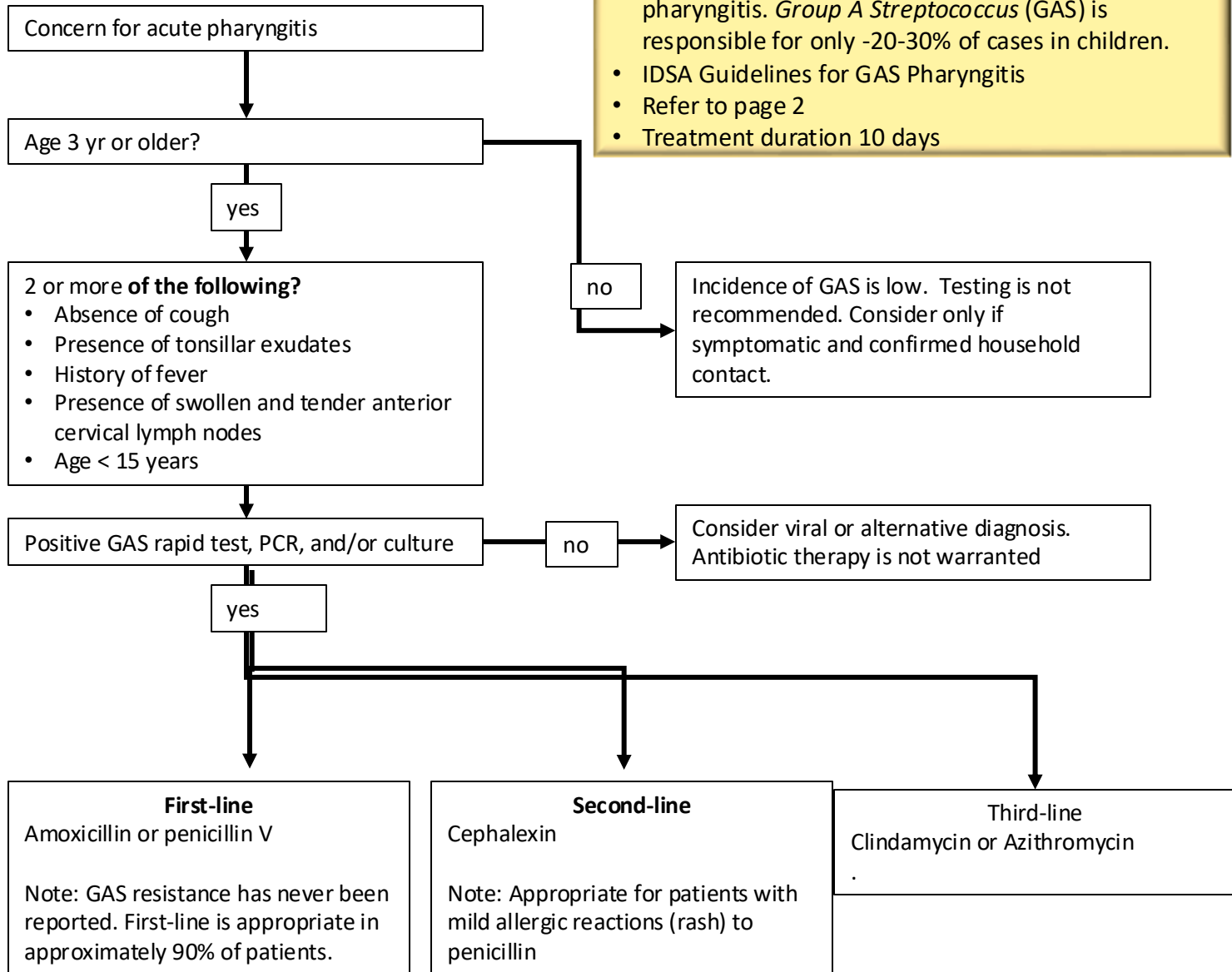


Uncomplicated Acute Pharyngitis

[Clinical Pearls](#)

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- Viruses are the most common cause of acute pharyngitis. *Group A Streptococcus* (GAS) is responsible for only ~20-30% of cases in children.
- IDSA Guidelines for GAS Pharyngitis
- Refer to page 2
- Treatment duration 10 days



Clinical decision points

- Follow-up testing after antibiotic treatment is not recommended. Positive results are usually indicative of a streptococcal carrier and further antibiotic treatment is not warranted
- Over-testing and treatment of acute pharyngitis in adults and children lead to an estimated 7 million courses of unnecessary antibiotics per year²
- Cefdinir is not recommended as an alternate treatment for children in IDSA GAS guidelines¹ and is not preferred for treatment of pediatric upper respiratory infections due to (1) poor pharmacokinetic (PK) characteristics; (2) high rates of resistance; and (3) broad but mismatched spectrum of coverage^{3,4,5}
- Up to 90% of penicillin allergies are misdiagnosed. Always clarify history of allergy and de-label
- if appropriate (e.g. family history without patient history). For more information on patient screening, contact the ASP pharmacist (502-629-5568) or consider referral to outpatient allergy.

Antibiotic dosing

- **Amoxicillin** 50 mg/kg oral once daily (max 1000 mg) or 25 mg/kg BID (max 500 mg)
- **Penicillin V, oral**
 - Children: 250 mg BID or TID; adolescents and adults: 250 mg QID or 500 mg BID
- **Benzathine penicillin G, IM**
 - <27 kg: 600,000 U; ≥27 kg: 1,200,000 U
- Cephalexin 20 mg/kg oral BID (max 500 mg/dose)
- Clindamycin 7 mg/kg oral TID (max 300 mg/dose)
- Azithromycin 12 mg/kg oral once daily (max 500 mg)

Bibliography

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2. Fleming-Dutra KE, Hersh AL, Shapiro DJ, et al. 2016. Prevalence of inappropriate antibiotic prescriptions among US ambulatory care visits, 2010-2011. *Jama*, 315(17), pp.1864-1873.
3. Wattles B, Vidwan N, Ghosal S, Feygin Y, Creel L, Myers J, Woods C, Smith M. Cefdinir use in the Kentucky Medicaid population: a priority for outpatient antimicrobial stewardship. *Journal of the Pediatric Infectious Diseases Society*. 2021 Feb;10(2):157-60.
4. Parker S, Mitchell M, Child J. Cephem antibiotics: wise use today preserves cure for tomorrow. *Pediatr Rev* 2013; 34:510—23; quiz 523—4.
5. Harrison CJ, Woods C, Stout G, et al. Susceptibilities of *Haemophilus influenzae*, *Streptococcus pneumoniae*, including serotype 19A, and *Ureaplasma* catarrhalis/parvum isolates from 2005 to 2007 to commonly used antibiotics. *J Antimicrob Chemother* 2009; 63:511—9.
7. Committee on Infectious Diseases, System-based treatment table editors: Kimberlin DW, Barnett ED, Lynfield R, Sawyer MH, et al. *Red Book 2021-2024 Report of the Committee on Infectious Diseases*. 32 ed. Itasca, IL: American Academy of Pediatrics; 2021:990-1003.

The policies set forth in this policy library do not establish a standard to be followed in every case. It is impossible to anticipate all possible solutions that may exist and to prepare policies for each. These policies should be considered guidelines with the understanding that departures from them may be required at times. Accordingly, it is recognized that those individuals employed in providing healthcare are expected to use their own judgment in determining what is in the best interests of the patient based on the circumstances existing at the time. If a policy contains references to clinical literature or other resources, such as Lippincott, Ovid, and/or Elsevier, these resources are only intended to support the reasoning for adoption of certain guidelines contained herein. It is not an endorsement of any article or text as authoritative. Norton Healthcare specifically recognizes there may be articles or texts containing other opinions on point that may be helpful and valid which would support other care or actions, given a particular set of circumstances. No literature is ever intended to replace the education, training and experience or exercise of judgment of the healthcare providers.

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