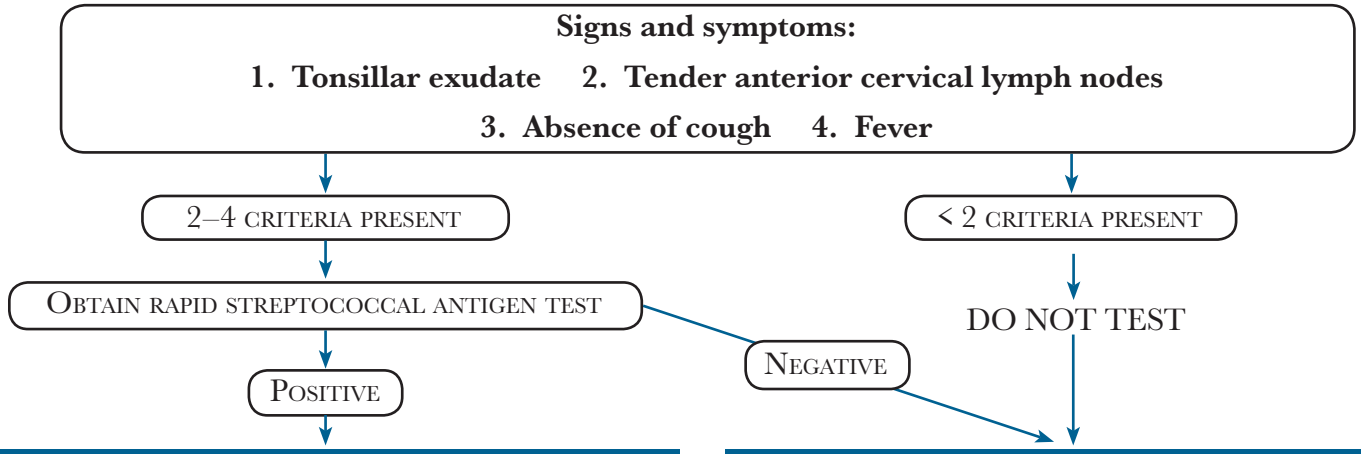
Practice Guidance for Judicious Use of Antibiotics

In the well-appearing patient, antibiotics are not the answer.

Pharyngitis in Children and Adults



Group A Streptococcal Pharyngitis Management

Adults: single-dose benzathine penicillin 1.2 million units IM or penicillin V 500 mg po bid x 10 days.

Children < 12 years: single-dose benzathine penicillin 25,000 units/kg IM (max. dose 1.2 million units) or amoxicillin or penicillin V 50 mg/kg/day po divided bid or tid x 10 days.

Mild penicillin allergy: (no hives or anaphylaxis): cephalexin or cefadroxil.

Severe allergy: clindamycin

Children with streptococcal pharyngitis should not return to school or child care during the first 24 hours after beginning antimicrobial therapy. Follow-up throat culture is not recommended.

Viral Pharyngitis Management

90% of pharyngitis is viral in origin.

Antibiotics benefit only the 10% of cases caused by Group A beta-hemolytic streptococcus.

Symptomatic treatments:

- Avoid cigarette smoke
- Gargle with dilute salt water
- Acetaminophen or ibuprofen as needed for fever or pain
- Throat lozenges (age-appropriate)
- Hydration—drink plenty of liquids
- Adequate rest

For children, a negative rapid antigen test should be confirmed with a throat culture. Due to the lower incidence of strep infection and acute rheumatic fever in adults, a negative rapid test alone is sufficient to rule out Group A strep infection in adults.*

* According to Clinical Laboratory Improvement Amendments (CLIA) guidelines, throat culture should be performed if required by the manufacturer.

These guidelines were produced in collaboration with the Infectious Diseases Society of Oregon.

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