

# Group A Strep Pharyngitis

## FAST FACTS

Concerns for tonsillectomy for recurrent Group A strep typically are not warranted unless the child has had:

- **>7 episodes/yr**
  - **>5 episodes/yr in the past 2 years**
- OR**
- **>3 episodes/yr in the past 3 years**

## WHEN TO REFER

Refer to the Cincinnati Children's Infectious Disease Clinic at **513-636-4578** if:

- Concerns about other etiologies
- Group A strep does not improve after management
- You need additional insights about a more complex case

Refer to the Ear, Nose and Throat Clinic, **513-636-4355**, if concerns for tonsillectomy.

**For urgent issues or to speak with a pediatric infectious disease specialist on call 24/7, call the Physician Priority Link® at 1-888-987-7997.**

**Acute pharyngitis is the most common Group A infection and typically spread through direct person-to-person transmission.**

## ASSESSMENT

Perform a standard history and physical exam (HPE). On clinical examination, patients with group A strep pharyngitis usually have:

- Anterior cervical lymphadenopathy
- Palatal petechiae
- Strawberry tongue
- Pharyngeal and tonsillar erythema
- Tonsillar hypertrophy with or without exudates

Scarlet fever may also occur and involves a characteristic erythematous sandpaper-like rash.

To confirm diagnosis, use a rapid antigen detection test or throat culture. Avoid testing in first couple days of an illness with other viral symptoms (cough, rhinorrhea, pharyngeal blisters) and no exposures or physical exam findings to support an infection with strep.

## HISTORY AND PHYSICAL EXAM RED FLAGS

Complications are rare in children who receive adequate therapy, but include invasive infections such as peritonsillar abscess or suppurative cervical lymphadenitis.

## MANAGEMENT

The goal of treatment of Group A strep is to reduce acute morbidity, suppurative and nonsuppurative complications (acute rheumatic fever and acute glomerulonephritis), and transmission to close contacts.

Antibiotic prophylaxis for household contacts is typically not required. Throat culture surveys of healthy asymptomatic children during the strep season yield Group A strep infection prevalence rates as high as 25%. Antimicrobial therapy is not indicated for most Group A strep pharyngeal carriers.

**First-line treatment is amoxicillin or penicillin VK (PCN VK) as follows** (see additional information on next page).

- Amoxicillin 50 mg/kg/day divided BID or QD (max 1000 mg/day)
- PCN VK
  - 250 mg/dose 2–3 times per day for 10 days for children less than 27 kg
  - 500 mg/dose 2–3 times per day for 10 days for children over 27 kg

If a patient does not respond to amoxicillin or PCN VK, consider looking for additional/alternative diagnoses (viral illness such as EBV, enterovirus) or complications such as peritonsillar abscess.

### Considerations for PCN allergy

For mild PCN allergy, providers can use 1st generation cephalosporin. If significant PCN allergy, consider azithromycin. Clindamycin is an alternative. Monitor for lack of response.

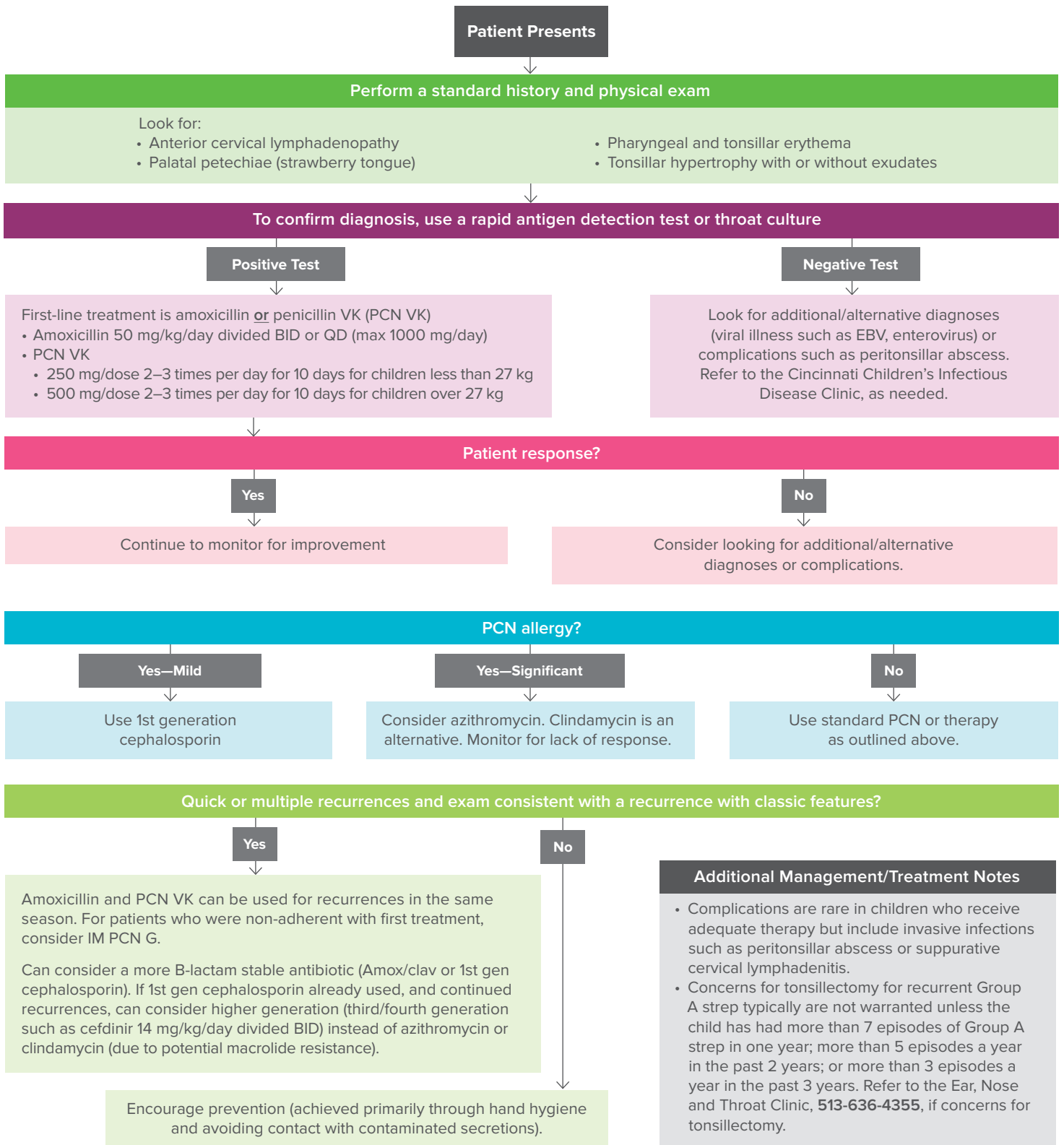
### Recurrences

Amoxicillin and PCN VK can be used for recurrences in the same season. For patients who were non-adherent with first treatment, consider penicillin B benzathine (IM PCN G). See guidance on next page for managing patients with quick or multiple recurrences.

See next page for guidance about treating continued recurrences.

If you would like additional copies of this tool, or would like more information, please contact the Physician Outreach and Engagement team at Cincinnati Children's.

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