Clinical Practice Guideline for Pediatric and Adult Pharyngitis

Sore throat is a common chief complaint of adults treated in outpatient settings. Although its differential diagnosis is large and includes other causes important to recognize, the majority of immunocompetent adults presenting with sore throat have acute infectious pharyngitis. Acute pharyngitis accounts for 1-2% of visits to outpatient departments, physician offices, and emergency departments. A range of infectious agents, most commonly viruses, cause acute pharyngitis. Approximately 5-15% of cases in adults (15-30% in children) are caused by group A beta-hemolytic streptococcus (GABS). In some patients, it can be important to identify an infectious cause other than GABHS (e.g., gonococcal pharyngitis, Epstein-Barr virus, acute HIV infection); a majority of cases in an otherwise healthy adult is self-limited and rarely produces significant sequelae. Antibiotics are prescribed to a substantial majority of adult members with acute pharyngitis.

**Goals of Clinical Practice Guideline**

- Reduce testing of members for GABS who present with concomitant VURI symptoms. The goal is for every member treated for strep throat to have a test documenting GABS.
- Reduce excessive antibiotic treatment through decreased empiric treatment of members with pharyngitis. Antibiotic treatment should be reserved for a bacterial illness.
- Increase the use of recommended first-line medications for members with pharyngitis.
- Increase member knowledge about pharyngitis and pharyngitis care.
- Increase the use of prophylactic medications for patients with seasonal allergic rhinitis.
- Decrease the use of injectable corticosteroid therapy for patients with allergic rhinitis.
- Increase the use of first-line antibiotics when indicated for patients diagnosed with acute sinusitis.

**Member ≥ 4 Years Old Complains of Sore Throat**

If symptoms indicate possible GABS, perform (MPGABS) or Rapid Strep Test (RST). If test is negative then educate on non-strep pharyngitis and home remedies. If test is positive, then go to the Treatment Section.

If member presents with symptoms of viral upper respiratory tract infection (VURI), treat accordingly. Symptoms include nasal congestion and discharge, cough and/or hoarseness.

**Common symptoms** associated with group A beta streptococcal (GABS) pharyngitis:

- Sudden onset of sore throat
- Fever, headache, patchy discrete exudate
- Nausea, vomiting, and abdominal pain
- History of exposure

**Occasional symptoms** associated with streptococcal pharyngitis include vomiting, malaise, anorexia, rash or urticaria.
Severe symptoms are those judged to be worrisome and may include:
- Stridor, drooling or shortness of breath
- Respiratory distress (not due to congestion)
- Inability to swallow liquids
- Trismus (inability to open mouth fully)

Complicating factors and conditions may include:
- Chronic illness/disease (CHF, HIV/AIDS, COPD, sickle-cell disease, etc.)
- History of Rheumatic Fever
- Member receiving chemotherapy
- Immunocompromised / Immunosuppressed
- Diagnosed with asthma or diabetes mellitus
- Member started antibiotics prior to diagnosis
- Members who smoke
- Members who are elderly or pregnant
- Symptoms of whooping cough or recent exposure
- Sore throat for > 5 days duration
- Persistent infection/treatment failure-recurrence of symptoms < 7 days of completing antibiotic therapy
- Recurrent streptococcal pharyngitis-recurrence of culture positive GABS pharyngitis more than 7 days but within 4 weeks of completing antibiotic therapy

Treatment

Antibiotic therapy should only be used if a positive MPGABS or RST result is obtained, indicating strep (GABS) pharyngitis. Please consult the WellCare Preferred Drug List for more information on available drug therapies.

Treatment of Primary Episodes
- **Penicillin** is the drug of choice for treatment of GABS pharyngitis.
- For members unable to swallow pills amoxicillin is advised due to the poor palatability of the penicillin suspension.
- If the possibility of poor compliance is a concern, IM penicillin may be advisable.
- In penicillin-allergic members, **erythromycin** is preferred. If an adverse reaction was not anaphylaxis, **cephalexin** is a reasonable choice or **clindamycin**.
- In penicillin and erythromycin allergic members, consideration should be given to spectrum and cost of antibiotic chosen.
- Although the broader spectrum penicillins (e.g., ampicillin, amoxicillin) are often used for treatment, they offer no microbiologic advantage over the narrower spectrum penicillin and **SHOULD BE AVOIDED**.
- Alternative medications include: **Macrolides, Cephalexin, Clindamycin, Amoxicillin/clavulanate, or Rocephin**.

Educate members on the importance of following the prescribed medication regimen, actions to take if symptoms worsen after 3-5 days (or new symptoms develop or symptoms do not improve after 14 days). Further, educate members on the importance of minimizing contact with others while contagious and use of home remedies to relieve symptoms. **Home remedies** include:
- Take acetaminophen or ibuprofen. Note: Aspirin use in children / teenagers may increase the risk of Reyes Syndrome.
- Gargle with warm salt water (1/4 teaspoon of salt per 8 ounces of water).
- Adults or older children may suck on throat lozenges, hard candy or ice. Gargling with ice water can be soothing.
- Eat soft foods, drink cool beverages or warm liquids, and suck on flavored frozen desserts.

For members with persistent infections and treatment failure, episodes should be documented by clinical findings and positive lab tests within 7 days after completion of a course of antibiotic therapy. Recommended antibiotics include:
- Erythromycin
- Cephalexin
- Clindamycin
- Amoxicillin/clavulanate

Assess if the member is on antibiotics for any other condition(s). If member is taking antibiotics as prescribed (other than sulfa, tetracycline, nitrofurantoin or other non-strep antibiotics) and develops a sore throat, the sore throat is likely caused by something other than GABS. Treatment failure for GABS is rare. Provide education on home remedies for sore throats and instruct member to call if symptoms worsen or persist beyond 5-7 days.
Antibiotic Treatment Table

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
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<tbody>
<tr>
<td>Penicillin V Potassium (PCN-VK)</td>
<td>• ≤ 50 lbs, 250 mg bid x 10 days</td>
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<tr>
<td></td>
<td>• &gt; 50 lbs, 500 mg bid x 10 days</td>
</tr>
<tr>
<td>Penicillin G Benzathine</td>
<td>• ≤ 60 lbs, 600,000 UIM x 1 dose</td>
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<tr>
<td></td>
<td>• &gt; 60 lbs, 1,200,000 UIM x 1 dose</td>
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<tr>
<td>Erythromycin</td>
<td>• Estolate 20-30 mg/kg/day ÷ bid – qid x 10 days</td>
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<td></td>
<td>• Ethyl succinate or stearate (&lt; 90 lbs), 400 mg qid x 10 days</td>
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<tr>
<td>Cephalixin</td>
<td>• Pediatric 25-50 mg/kg/day ÷ bid x 10 days</td>
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<tr>
<td></td>
<td>• Adults 500 mg bid x 10 days</td>
</tr>
<tr>
<td>Clindamycin</td>
<td>• Pediatric 20 mg/kg/day ÷ tid x 10 days</td>
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<tr>
<td></td>
<td>• Adults 450 mg/day ÷ tid x 10 days</td>
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CMS STAR METRIC

CMS has not published a metric for this condition.

NCQA HEDIS STANDARD

The percentage of children 2 to 18 years of age who were diagnosed with only pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

REFERENCES


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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>History and Revisions by the Medical Policy Committee</th>
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<tbody>
<tr>
<td>11/6/2014</td>
<td>• Approved by MPC. Updated with 2013 ICSI guideline. No changes.</td>
</tr>
<tr>
<td>10/4/2012</td>
<td>• Approved by MPC. Updated 2008 recommendations with 2011 ICSI guideline.</td>
</tr>
<tr>
<td>12/1/2011</td>
<td>• New template design approved by MPC.</td>
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<tr>
<td>10/2010</td>
<td>• New. Approved by MPC.</td>
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