PEDIATRIC EMERGENCY MEDICINE EVIDENCE-BASED PATHWAY

ACUTE PHARYNGITIS

UCSF Benioff Children's Hospital San Francisco

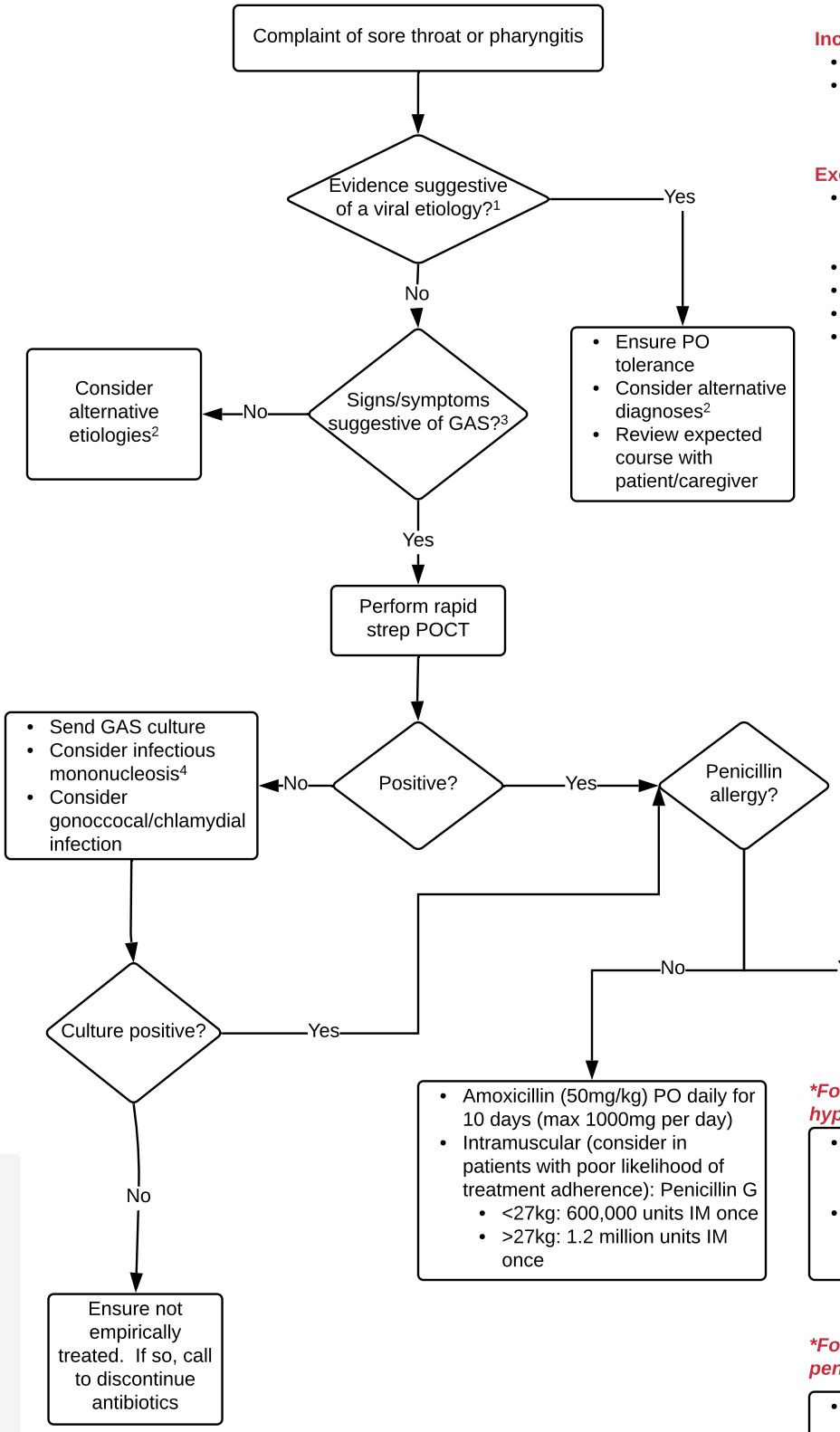
1. Evidence suggestive of viral etiology:
- Cough, coryza, oral ulcerations, marked rhinorrhea

2. Consider following:
- Epiglottitis
- Retropharyngeal abscess
- Peritonsillar abscess
- Lemierre's Syndrome
- Diphtheria
- Airway obstruction

3. Signs and/or symptoms suggestive of GAS:
- Tonsillar exudate
- Tender anterior cervical lymphadenopathy
- Palatal petechiae
- Fever
- Consider atypical symptoms (e.g., headache, abdominal pain, vomiting).

4. Infectious mononucleosis testing
- Testing after first week of illness?
- Monospot/heterophile antibody: 85% sensitive, 94% specific
- Atypical lymphocytes: 75% sensitive, 92% specifici
- Consider both CBC and monospot if applicable

5. Discharge criteria
- Able to tolerate PO
- Able to obtain prescriptions
- Ensure appropriate school release
- Consider first dose of antibiotic in ED



Inclusion Criteria:
- Age 3 years - 18 years
- Complaint of sore throat and/or evidence of pharyngitis

Exclusion Criteria:
- Immunocompromised (chemotherapy, DMARD, HIV, or congenital immunodeficiency)
- Unvaccinated or undervaccinated
- Evidence of sepsis or shock
- Toxic appearance
- Pharyngeal or oral trauma

Common management questions

Test and treat household contacts?
- Not routinely
- Only if symptomatic

Indications for steroids?
- Not routinely recommended or supported by evidence
- Can consider for severe symptoms

Return to school/care?
- Afebrile
- Antibiotics for > 12 hours, if indicated

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Disclaimer: This algorithm functions as a guideline for clinical care under the direction of pediatric emergency medicine attendings.