PHARYNGITIS

NAT'S NOTES IN OTOLARYNGOLOGY HEAD AND NECK SURGERY

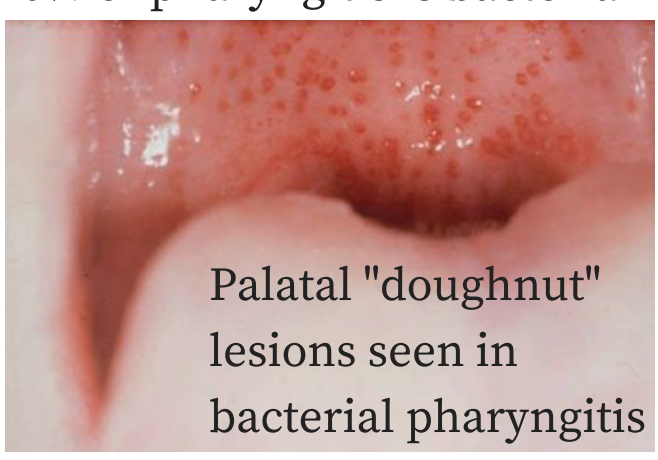
Episode 12.1

PHARYNGITIS

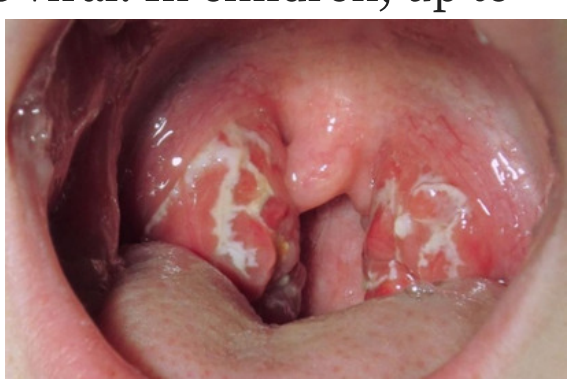
Inflammation of mucosal / submucosal layers of pharynx.
High concentration of lymphoid tissue (Waldeyer's Ring) means affected tissues may be in nasopharynx (adenoids), oropharynx (palatine tonsils) or hypopharynx
Usually a clinical diagnosis

BACTERIAL VERSUS VIRAL

Viral → low grade fever, rhinorrhea, malaise and cough
Bacterial → high grade fever, exudate, absence of URTI Sx
In adults, up to 90% of pharyngitis is viral. In children, up to 40% of pharyngitis is bacterial



Palatal "doughnut" lesions seen in bacterial pharyngitis



Bacterial tonsillar exudates

CAUSES OF PHARYNGITIS

Bacterial	B-hemolytic streptococcus, non-GABHS, syphillis, chlamydia
Viral	Epstein-Barr, coronavirus, rhinovirus
Fungal	Candida albicans
Granulomatous	Sarcoidosis, TB, crohn's disease
Radiation induced	
Reflux associated	

GROUP A-BETA HEMOLYTIC STREP

(Strep pyogenes)
Diagnosis using Centor Criteria: 1) pharyngeal / tonsillar exudate, 2) swollen anterior cervical chain nodes, 3) fever > 38C and 4) absence of cough. Centor 3/4 warrants antibiotic therapy. Penicillin V 300mg PO TID (clindamycin if PCN allergic). Antibiotics reduce transmission, complications of GABHS (rheumatic fever) and duration of symptoms (-1 day)

INFECTIOUS MONONUCLEOSIS

Epstein-Barr virus - transmission via saliva, long 30-50 day incubation. Clinical triad: fever, lymphadenopathy (94%) and pharyngitis. 52% have splenomegaly. Complications: hemolytic anemia, CN palsies, pericarditis and hepatitis

On history, rule out URTI sxs (coryza, cough)!
On PMHx, rule out immunocompromise!
Inquire about sexual history and smoking status!