

A Watchful waiting is more appropriate than tonsillectomy for children with mild sore throats.

A Tonsillectomy is recommended for recurrent severe sore throat in adults.

D The following are recommended as indications for consideration of tonsillectomy for recurrent acute sore throat in both children and adults:

- sore throats are due to acute tonsillitis
- the episodes of sore throat are disabling and prevent normal functioning
- seven or more well documented, clinically significant, adequately treated sore throats in the preceding year or
- five or more such episodes in each of the preceding two years or
- three or more such episodes in each of the preceding three years.

Cognisance should also be taken of whether the frequency of episodes is increasing or decreasing.

Evidence on exactly which children with sore throats benefit from tonsillectomy is not available, but current evidence suggests that the benefit of tonsillectomy increases with the severity and frequency of sore throats prior to tonsillectomy. Apart from adults with proven recurrent group A streptococcal pharyngitis, evidence on which adults will benefit from tonsillectomy is not available.

There are situations in which tonsillectomy may be appropriate outwith these criteria. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan.

This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available.

When in doubt as to whether tonsillectomy would be beneficial, a six month period of watchful waiting is recommended prior to consideration of tonsillectomy to establish firmly the pattern of symptoms and allow the patient to consider fully the implications of an operation.

At the time of discharge, patients/carers should be provided with written information advising them whom to contact and at what hospital unit or department to present if they have postoperative problems or complications.

D Patients should be made aware of the potential for pain to increase for up to 6 days following tonsillectomy.

Patients/carers should be given written and oral instruction prior to discharge from hospital on the expected pain profile and the safety profile of the analgesic(s) issued with particular reference to appropriate dose and duration of use. They should be issued with enough analgesic to last for a week.

A Routine use of anti-emetic drugs to prevent postoperative nausea and vomiting (PONV) in tonsillectomy is recommended.

A NSAIDs are recommended as part of postoperative analgesia to reduce PONV.

A A single intraoperative dose of dexamethasone (dose range 0.15 to 1.0 mg/kg; maximum dose range 8 to 25 mg) is recommended to prevent postoperative vomiting in children undergoing tonsillectomy or adenotonsillectomy.

B A single dose of 10 mg dexamethasone at induction of anaesthesia may be considered to prevent PONV in adults undergoing tonsillectomy or adenotonsillectomy.

B Stimulation of the acupuncture point P6 should be routinely considered in patients at risk of PONV where anti-emetic drug prophylaxis is not suitable.

This Quick Reference Guide provides a summary of the main recommendations in **SIGN guideline 117: Management of sore throat and indications for tonsillectomy.**

Recommendations are graded **A B C D** to indicate the strength of the supporting evidence. Good practice points are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: www.sign.ac.uk

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Management of sore throat and indications for tonsillectomy
Quick Reference Guide



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PRESENTATION AND DIAGNOSIS IN GENERAL PRACTICE

C Practitioners should be aware of underlying psychosocial influences in patients presenting with sore throat.

Sore throat associated with stridor or respiratory difficulty is an absolute indication for admission to hospital.

C The Centor clinical prediction score should be used to assist the decision on whether to prescribe an antibiotic, but cannot be relied upon for a precise diagnosis.

The Centor score gives one point each for:

- tonsillar exudate
- tender anterior cervical lymph nodes
- history of fever
- absence of cough.

The likelihood of group A beta-haemolytic streptococcus (GABHS) infection increases with increasing score, and is between 25-86% with a score of 4 and 2-23% with a score of 1, depending upon age, local prevalence and seasonal variation.

Streptococcal infection is most likely in the 5–15 year old age group and gets progressively less likely in younger or older patients. The score is not validated for use in children under three years.

D Throat swabs should not be carried out routinely in primary care management of sore throat.

Throat swabs may be used to establish aetiology of recurrent severe episodes in adults when considering referral for tonsillectomy.

If breathing difficulty is present, urgent referral to hospital is mandatory and attempts to examine the throat should be avoided.

GENERAL MANAGEMENT OF SORE THROAT

Diagnosis of a sore throat does not mean that an antibiotic has to be administered. Adequate analgesia will usually be all that is required.

ANALGESIA IN ADULTS

A Ibuprofen 400 mg three times daily is recommended for relief of fever, headache and throat pain in adults with sore throat.

A In adults with sore throat who are intolerant to ibuprofen, paracetamol 1 g four times daily when required is recommended for symptom relief.

ANALGESIA IN CHILDREN

In children with sore throat, an adequate dose of paracetamol should be used as first line treatment for pain relief.

A Ibuprofen can be used as an alternative to paracetamol in children.

D Ibuprofen should not be given routinely to children with or at risk of dehydration.

ADJUNCTIVE THERAPIES

B Echinacea purpurea is not recommended for treatment of sore throat.

No good quality evidence on the effectiveness of non-prescription throat sprays, lozenges and gargles was identified.

Evidence on corticosteroids for pharyngitis is conflicting and no recommendation is made.

In patients with acute glandular fever (infectious mononucleosis) requiring hospitalisation, corticosteroids may have a role when pain and swelling threaten the airway or where there is very severe dysphagia.

ANTIBIOTICS IN ACUTE AND RECURRENT SORE THROAT

A Antibiotics should not be used to secure symptomatic relief in sore throat.

Antibiotic prophylaxis for recurrent sore throat is not recommended.

In view of increases in healthcare-acquired infections and antibiotic resistance in the community, unnecessary prescribing of antibiotics for minor self limiting illness should be avoided.

In severe cases, where the practitioner is concerned about the clinical condition of the patient, antibiotics should not be withheld. (Penicillin V 500 mg four times daily for 10 days is the dosage used in the majority of studies. A macrolide can be considered as an alternative first line treatment, in line with local guidance.)

In certain unusual circumstances, such as epidemics, more widespread prescription of antibiotics may be recommended and the relevant public health guidance should be followed.

Ampicillin-based antibiotics, including co-amoxiclav, should not be used for sore throat because these antibiotics may cause a rash when used in the presence of glandular fever.

C Sore throat should not be treated with antibiotics specifically to prevent the development of rheumatic fever and acute glomerulonephritis.

C Antibiotics may prevent cross infection with GABHS in closed institutions (such as barracks, boarding schools) but should not be used routinely to prevent cross infection in the general community.