



Complete Summary

GUIDELINE TITLE

Tonsillitis and pharyngitis in children.

BIBLIOGRAPHIC SOURCE(S)

Finnish Medical Society Duodecim. Tonsillitis and pharyngitis in children. In: EBM Guidelines. Evidence-Based Medicine [Internet]. Helsinki, Finland: Wiley Interscience. John Wiley & Sons; 2007 May 30 [Various].

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Finnish Medical Society Duodecim. Tonsillitis and pharyngitis in children. In: EBM Guidelines. Evidence-Based Medicine [Internet]. Helsinki, Finland: Wiley Interscience. John Wiley & Sons; 2005 Oct 30 [Various]. [1 reference]

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SCOPE

DISEASE/CONDITION(S)

Tonsillitis and pharyngitis

GUIDELINE CATEGORY

Diagnosis
Treatment

CLINICAL SPECIALTY

Family Practice
Otolaryngology
Pediatrics

INTENDED USERS

Health Care Providers
Physicians

GUIDELINE OBJECTIVE(S)

Evidence-Based Medicine Guidelines collect, summarize, and update the core clinical knowledge essential in general practice. The guidelines also describe the scientific evidence underlying the given recommendations.

TARGET POPULATION

Children with suspected or known tonsillitis and pharyngitis

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

Culture or rapid antigen test

Note: Guideline developers considered but did not recommend assessment of clinical features as a reliable diagnostic measure.

Treatment

1. Paracetamol, naproxen, or ibuprofen for fever and pain
2. Penicillin or cephalixin
3. Isolation of infected child from daycare or school for one day after onset of antibiotic treatment

MAJOR OUTCOMES CONSIDERED

- Cure rates
- Adverse effects of treatment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The evidence reviewed was collected from the Cochrane database of systematic reviews and the Database of Abstracts of Reviews of Effectiveness (DARE). In addition, the Cochrane Library and medical journals were searched specifically for original publications.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

A. Quality of Evidence: High

Further research is very unlikely to change confidence in the estimate of effect

- Several high-quality studies with consistent results
- In special cases: one large, high-quality multi-centre trial

B. Quality of Evidence: Moderate

Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.

- One high-quality study
- Several studies with some limitations

C. Quality of Evidence: Low

Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.

- One or more studies with severe limitations

D. Quality of Evidence: Very Low

Any estimate of effect is very uncertain.

- Expert opinion
- No direct research evidence
- One or more studies with very severe limitations

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The levels of evidence [A-D] supporting the recommendations are defined at the end of the "Major Recommendations" field.

Basic Rules

- Antibiotics are indicated in infections caused by group A streptococci diagnosed by culture or rapid antigen test. Symptomatic treatment is indicated in other cases.
- Infectious mononucleosis presents with only mild symptoms in small children. Treatment with antibiotics is of no use, but a course of amoxicillin during the disease will provoke a red-spotted rash in almost every patient.
- Epidemics caused by streptococci should be identified and managed. Contaminated food and milk are known to cause streptococcal epidemic.

Aetiology

- Adenoviruses are the most common aetiological agents.
- Streptococcal pharyngitis is rare in children below 3 years of age.

Symptoms and Signs

- Fever and sore throat are the main symptoms associated with streptococcal infection, but clinical diagnosis is unreliable.
 - Adenoviruses and other viruses can cause exudative tonsillitis.
 - In two thirds of school-aged children with streptococcal tonsillitis there is no exudate.
- If a patient with recent onset fever and sore throat also has cough and rhinitis, a viral respiratory infection is far more probable than streptococcal infection.
- Sore throat with rash is often caused by adenoviruses or other viruses.
- Ear pain may radiate to the tonsillar region (and vice versa).
- Streptococcal pharyngitis may cause abdominal pain.

Diagnostics

- Diagnosis should be based on the detection of streptococci in pharyngeal secretions by culture or rapid antigen test (see picture 1 in the original guideline document). Bacteria other than streptococci need not be sought.
- A rapid culture method (Streptocult®) will give a result the next morning (see Finnish Medical Society Duodecim guideline "Throat Bacterial Swab."). If a rapid antigen test is used, a negative result should be verified by culture. (In children below 3 years of age streptococcal tonsillitis is so rare that a negative antigen test need not be controlled by culture.)

Treatment

- Fever and pain are best treated with paracetamol. Naproxen and ibuprofen are alternatives. Infections caused by group A streptococci should be treated with penicillin V, 70 mg/kg/day (100,000 units/kg/day), or (in patients with penicillin allergy) cephalexin, 50 mg/kg/day, in two doses for 10 days (Deeter et al., 1992) [A].
- Because of infectiousness the child should be isolated from day care or school for one day after the onset of antibiotic treatment. The length of absence from day care or school is determined by the general condition and not by the aetiological agent.

Definitions:

Levels of Evidence

A. Quality of Evidence: High

Further research is very unlikely to change confidence in the estimate of effect

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- In special cases: one large, high-quality multi-centre trial

B. Quality of Evidence: Moderate

Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.

- One high-quality study
- Several studies with some limitations

C. Quality of Evidence: Low

Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.

- One or more studies with severe limitations

D. Quality of Evidence: Very Low

Any estimate of effect is very uncertain.

- Expert opinion
- No direct research evidence
- One or more studies with very severe limitations

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Concise summaries of scientific evidence attached to the individual guidelines are the unique feature of the Evidence-Based Medicine Guidelines. The evidence summaries allow the clinician to judge how well-founded the treatment recommendations are. The type of supporting evidence is identified and graded for select recommendations (see the "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and treatment of tonsillitis and pharyngitis

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Apr 21 (revised 2007 May 30)

GUIDELINE DEVELOPER(S)

Finnish Medical Society Duodecim - Professional Association

SOURCE(S) OF FUNDING

Finnish Medical Society Duodecim

GUIDELINE COMMITTEE

Editorial Team of EBM Guidelines

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Author: Marjukka Mäkelä

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

This guideline is included in a CD-ROM titled "EBM Guidelines. Evidence-Based Medicine" available from Duodecim Medical Publications, Ltd, PO Box 713, 00101 Helsinki, Finland; e-mail: info@ebm-guidelines.com; Web site: www.ebm-guidelines.com.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on August 31, 2005. This summary was updated by ECRI on March 17, 2006, and on January 8, 2008.

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