Throat disorder

- Pharyngitis & tonsilitis : infx of posterior pharynx by virus or bacteria, self-limiting

① Viral pharyngitis

- caused by adenovirus, RSV, influenza A&B, Epstein-Barr, coxsackie, enterovirus, herpes simplex
- Sx : mild/severe throat pain, throat pain/itch, rhinorrhea, conjunctivitis, cough

② Mononucleosis

⇒ by EBS, person-to-person contact by kissing, cough..

- Sx : fever, malaise, sore throat, exudative tonsilitis, palatal petechiae, rash, anterior/posterior lymphadenopathy, splenic enlargement
- test : POC mono spot test, CBC (atypical lymphocytes)
- Tx : symptomatic, takes weeks to cure, avoid contact sports (risk for splenic rupture)

③ Bacterial pharyngitis

⇒ by Group A Beta Hemolytic Streptococcus (GABHS) ← common in 5-15 yr old in winter - early spring which has complication of rheumatic fever, peritonsillar abscess, Scarlet fever, glomerulonephritis

- Sx : fever, sore throat, headache, malaise, neck pain, odynophagia, otalgia

• Odynophagia - pain while swallowing
• Otalgia - ear pain

- DDx for pharyngitis/tonsilitis : GABHS, epiglottitis, pharyngitis w/ post nasal drip, hand/foot/mouth disease (coxsackie virus), HSV-1, mononucleosis, stomatitis

• HUS-1 - herpes simplex virus - 1

- PE : erythema (U+B), exudates/enlarged tonsils (B), white to yellow exudate on tonsils, strawberry tongue, red/swollen uvula (streptococcal)

1 to 2 mm vesicular lesion on pharynx to gingiva, buccal mucosa, tongue & lips (HSV-1), oral lesion w/ exanthem on hands & feet (Hand/foot/mouth disease)

* Broad overlap of bacterial & viral pharyngitis, thus no need to test bacterial if conjunctivitis, cough, oral ulcer → viral are present

- Test: CBC, monospot, RAD (rapid strep antigen)/throat culture (*delayed result but high specificity & sensitivity)
- Sx bacterial: fever, tender anterior cervical adenopathy, ⊖ cough, pharyngotonsillar exudate

• ORSA need culture for sensitivity.

• Center criteria of GABHS infx

Bacterial
- Tx: penicillin VK 250mg TID or 500mg BID x 10days
  Amoxicillin ~ 1000mg daily (50mg/kg) → pt w/ PCN allergy
  Macrolide erythromycin (Azithromycin) 12mg/kg/day ~ 500mg daily x 5 days
- Mono + amoxicillin ⇒ 90% rash (not amoxicillin allergy)

* mono can be present w/ ORSA, or ⊕ GABHS

- Tx of viral/Bacterial - analgesics, anti-inflammatories, salt water gargle, anesthetic gargles/lozenges → severe case
  Tonsillectomy if ⇒ airway obstruction
  3x infx in 1yr

• Avoid ASA in children

④ Peritonsilar cellulitis & abscess

- acute pharyngeal infx among young people ⇒ by streptococcus & Staphylococcus
- Sx: gradual, severe unilateral sore throat, odynophagia, trismus, fever, otalgia, asymmetric cervical adenopathy, drooling, halitosis, tonsilar exudate, peritonsilar abscess ⇒ uvula deviation

• trismus - lockjaw due to spasm of muscle

• Halitosis - bad breath

• Refer to ER due to possible sepsis

⑤ Acute laryngitis

- inflammation of larynx => by infx (viral), chemical, allergies → H. influenza but few bacterial (Moraxella caterrhalis)
- Sx: weakened voice, hoarseness, dry cough → may last weeks
- Tx: mostly viral -> no med, lozenges / salt water gargle, resting voice • Supportive measure • resolve in a week

⑥ Bacterial tracheitis

- inflammation of larynx, trachea, branchi w/ mucus mostly occur at the narrowest part of airway, thus airway obstruction => by subglottic edema, sloughing of epithelial lining, and mucus → > cricoid cartilage level
- Sx: barking cough, stridor, fever, • Staphylococcus aureus • more common among children due to smaller airway
- Diagnosis: blood test, x-ray, tracheal culture
- Tx: airway support, abx • improve in 5 days