Both viral and bacterial pharyngitis are usually self-limited diseases. However, because of the risk for serious complications associated with streptococcal sore throat, an effort is usually made to establish an accurate diagnosis and treat bacterial pharyngitis.

- *Throat swab* is obtained and examined for streptococcus antigen using the latex agglutination (LA) antigen test or enzyme immunoassay (ELISA) testing. These tests allow rapid identification of the antigen (in as little as 10 minutes for the LA test) but are not highly sensitive. When the test is positive, treatment for strep throat is initiated. If the test is negative, the swab is cultured to ensure that streptococcus organisms are not present. Even throat cultures are not always accurate, with approximately 10% false negative and 20% false positive results.

- *Complete blood count (CBC)* may be done on severely ill clients or to rule out other causes of pharyngitis. The WBC count is usually normal or low in viral infections and elevated in bacterial infections.

Antipyretics and mild analgesics such as aspirin or acetaminophen provide symptomatic relief for throat pain and associated myalgias. Penicillin is the drug of choice for group A streptococci. Erythromycin, amoxicillin, or cefuroxime (Ceftin, Kefurox) may be used if the client is allergic to penicillin. Antibiotic therapy is continued for at least 10 days. The client is no longer contagious after 24 hours of antibiotic therapy.

A peritonsillar abscess is drained by needle aspiration or by incision and drainage. The area is first sprayed with a topical anesthetic such as cetacaine and then injected with a local anesthetic. The sitting position is preferred for the procedure, because it enables expectoration of blood and pus. Tonsillectomy is done either immediately or 6 weeks after incision and drainage of peritonsillar abscess.

Tonsillectomy (surgical removal of the tonsils) is indicated for recurrent or chronic infections that have not responded to antibiotic therapy, hypertrophy of the tonsils with risk of airway obstruction, peritonsillar abscess, repeated attacks of purulent otitis media, and tonsil malignancy. Adenoid tissue usually is removed at the same time. Bleeding is the most significant postoperative complication of tonsillectomy.

Because of the risk of significant complications associated with streptococcal pharyngitis, encourage all clients with symptoms that persist for several days or that include fever, lymphadenopathy, and myalgias to seek evaluation and treatment.

Home care is appropriate for acute uncomplicated pharyngitis. Treatment focuses on adequate rest and relief of symptoms. A liquid or soft diet is useful when swallowing is difficult. Increased fluid intake is encouraged, especially when febrile. Warm saline gargles, moist inhalations, and application of an ice collar are soothing to the sore throat.

Following tonsillectomy, ensure a patent airway by placing the client in semi-Fowler’s position with the head turned to the side to allow secretions to drain from the mouth and pharynx. Keep the airway in place until the gag and swallowing reflexes have returned. Apply an ice collar to reduce swelling and pain. Notify the surgeon immediately if excessive bleeding or hemorrhage occurs. If there is no bleeding, allow water and cracked ice as desired. Warm saline mouthwashes are helpful in managing thick oral secretions following tonsillectomy. A liquid or semiliquid diet is recommended for several days.

### Home Care
Discuss the following topics when preparing the client for home care.

- The importance of completing the full 10 days of antibiotic therapy if prescribed
- Using warm saline gargles or throat lozenges for symptomatic relief
- Signs and symptoms of possible complications of streptococcal infection such as glomerulonephritis or rheumatic fever
- Monitoring temperature in the morning and evening until well to ensure that the infection has not spread to deeper tissues
- Proper use and disposal of tissues and frequent handwashing to prevent spreading the infection to others

For the client who has had a peritonsillar abscess drainage or tonsillectomy, provide the following instructions.

- Postoperative mouth and throat care
- Avoiding use of aspirin for 2 weeks to reduce the risk of postoperative bleeding
- Manifestations of bleeding to report to the physician (delayed hemorrhage may occur for up to 1 week post surgery)

### Nursing Care Plan

### A Client with Peritonsillar Abscess

**Monica Wunderman, age 27, was recently treated for tonsillitis caused by infection by group A streptococcus. She presents to the emergency department 10 days later appearing acutely ill.**

She states that her throat is so sore that she has difficulty swallowing even liquids. Barbara Ironhorse, the ED nurse, completes an assessment of Ms. Wunderman.

**ASSESSMENT**

Findings include T 102°F (38.8°C). An acutely swollen and reddened area of the soft palate is noted in her mouth, half occluding the orifice from the mouth into the pharynx. Yellow exudate is present. CBC reveals an elevated WBC of 16,000/mm³. A diagnosis of peritonsillar abscess is made.

*(continued)*
THE CLIENT WITH A LARYNGEAL INFECTION

The larynx, located between the upper airways and the lungs, protects the lower respiratory tract from inhaled substances other than air, and allows speech. The larynx includes the epiglottis, which covers the larynx during swallowing, and the glottis, or vocal cords. Either portion of the larynx may become inflamed.

EPIGLOTTITIS

Epiglottitis, inflammation of the epiglottis, is an uncommon disorder that presents as a medical emergency. *H. influenzae* infection is the most common cause of epiglottitis. Epiglottitis is a rapidly progressive cellulitis that begins between the base of the tongue and the epiglottis. The epiglottis itself becomes swollen and inflamed; swelling of adjacent tissues pushes the epiglottis posteriorly. This swelling and edema threatens the airway. Adults usually present with a 1- to 2-day history of sore throat, *odynophagia* (painful swallowing), dyspnea, and possibly drooling and stridor.

Using a tongue blade to view the oropharynx is avoided; this may precipitate laryngospasm and airway obstruction. The epiglottis is visualized using a flexible fiberoptic laryngoscope to establish the diagnosis. The epiglottitis appears red, swollen, and edematous. Nasotracheal intubation may be required to ensure airway patency. The client is admitted to a critical care unit and intravenous antibiotic therapy is initiated. Ceftriaxone (Rocephin), cefuroxime (Ceftin), or ampicillin/sulbactam (Unasyn) may be prescribed. If allergic to penicillin, a combination of clindamycin (Cleocin) and either trimethoprim-sulfamethoxazole (TMP-SMZ) or ciprofloxacin (Cipro) may be used. Dexamethasone, a systemic corticosteroid, is also given to suppress the inflammatory response and rapidly reduce swelling of the epiglottis.

Nursing care for the client with acute epiglottitis focuses on monitoring and maintaining airway patency. Monitor oxygen saturation continuously. Observe closely for signs of airway obstruction, including nasal flaring, restlessness, stridor, use of accessory muscles, and decreased oxygen saturation measurements. If the client is not intubated, supplies for emergency intubation should be kept in the unit. Epiglottitis is frightening for both the client and the nurse. Maintaining a calm, reassuring manner is an essential nursing role.

LARYNGITIS

Laryngitis, inflammation of the larynx, is a common disorder that may occur alone or in conjunction with other upper respiratory infections. It is commonly associated with viral URI such as influenza. It may also occur with bronchitis, pneumo-