Chapter 35: Upper Respiratory Symptoms, Including Earache, Sinus Symptoms, and Sore Throat

Rachel L. Amdur; Jeffrey A. Linder

INTRODUCTION

Upper respiratory symptoms are most commonly caused by viral infection but also can be caused by other infectious, inflammatory, allergic, autoimmune, and neoplastic conditions. This chapter will discuss ambulatory antibiotic prescribing and review the most common causes of upper respiratory symptoms, including nonspecific upper respiratory infections.

Ear pain is most commonly caused by otitis externa, acute otitis media (AOM), otitis media with effusion (OME), and acute mastoiditis. Sinus symptoms can be caused by acute sinusitis, invasive fungal sinusitis, nosocomial sinusitis, and chronic sinusitis. Sore throat and neck pain can be caused by streptococcal pharyngitis, nonstreptococcal pharyngitis, acute infectious mononucleosis, other types of bacterial pharyngitis, Lemierre's syndrome, gonococcal pharyngitis, diphtheria, acute HIV infection, head and neck abscesses, epiglottitis, and laryngitis. At the time of presentation, upper respiratory symptoms of most common viral and bacterial etiologies have generally lasted from hours up to a few days.

UPPER RESPIRATORY INFECTIONS

Upper respiratory infections (URIs) are acute respiratory infections that occur above the vocal cords. URIs, including nonspecific upper respiratory tract infection, otitis media, sinusitis, and pharyngitis, are collectively the most common symptomatic reason for seeking care in the United States. In terms of etiology, symptoms, and signs, URIs overlap with lower acute respiratory infections that occur below the vocal cords, such as influenza **(Chap. 200)**, acute bronchitis, and pneumonia **(Chap. 126)**, as well as with noninfectious cough **(Chap. 38)**. The average adult has 2–4 URIs per year; children can have 6–10 URIs annually. URIs can be prevented by hand washing or sanitization, physical distancing, use of facial masks, isolation of persons who are ill, and environmental cleaning **(Chap. 199)**.

SARS-CoV-2, the pathogen that causes COVID-19, can cause virtually any upper respiratory symptom **(Chap. 199)**. COVID-19 symptoms appear 2–14 days after exposure and may include fever, chills, cough, shortness of breath, fatigue, myalgias, headaches, rhinorrhea, sore throat, nausea, vomiting, or diarrhea. New loss of taste or smell appears to be specific for COVID-19. Until there is widespread natural or vaccine-induced immunity, any respiratory symptom occurring in areas where SARS-CoV-2 is circulating should be considered a potential manifestation of COVID-19.

IMPROVING AMBULATORY ANTIBIOTIC PRESCRIBING

The only common acute respiratory infections that should be treated with antibiotics are AOM, sinusitis, streptococcal pharyngitis, and pneumonia. Even for AOM, sinusitis, and pharyngitis, only a minority of cases meet the criteria for antibiotic prescribing. Common respiratory viruses **(Chap. 199)** cause the overwhelming majority of acute respiratory infections, and these infections are generally self-limited; antibiotics neither speed resolution nor prevent complications for the majority of acute respiratory infections. Unfortunately, for this reason, at least half of ambulatory antibiotic prescriptions for acute respiratory infections in the United States are inappropriate. Internationally, population rates of antibiotic prescribing vary nearly threefold, with no differences in infectious complications. Antibiotics cause adverse drug effects, alter the microbiome, cause *Clostridioides difficile* infection **(Chap. 134)**, increase health care costs, and increase the prevalence of antibiotic-resistant bacteria **(Chap. 145)**.

Clinicians prescribe inappropriate antibiotics because of time pressure; fear of missing a rare bacterial diagnosis; concern about preventing a rare bacterial complication; a lack of salience of adverse antibiotic effects; or a mistaken belief that most patients expect, demand, or will not be satisfied without an antibiotic prescription.

AMBULATORY ANTIBIOTIC STEWARDSHIP

Antibiotic stewardship has traditionally been an inpatient concern **(Chap. 144)**, but ambulatory antibiotic use accounts for ~85% of antibiotic use by patients in most developed countries. In 2016, the Centers for Disease Control and Prevention published the "Core Elements of Outpatient Antibiotic Stewardship." The core elements include (1) committing to improving antibiotic prescribing; (2) implementing at least one policy or practice to improve antibiotic prescribing and assessing its effectiveness; (3) monitoring antibiotic prescribing and providing feedback; and (4) providing educational resources to clinicians and patients on antibiotic prescribing. Effective interventions to decrease inappropriate ambulatory antibiotic prescribing include peer comparison, accountable justification, precommitment, clinical decision support, patient education, and multifaceted interventions. Communication training has been particularly effective when it includes making a clear diagnosis, focusing on positive actions patients can take to feel better, reviewing the expected course of illness, and informing patients about concerning symptoms (red flags) for which they should seek or reconnect with care. Telemedicine—synchronous telephone or video or asynchronous electronic messaging—has the potential to improve patient convenience and reduce inappropriate antibiotic prescribing.

Several techniques that seemed promising for the reduction of ambulatory antibiotic prescribing remain unproven, have been ineffective (e.g., procalcitonin testing), or are not durable (e.g., C-reactive protein testing). The practice of delayed antibiotic prescription—i.e., a prescription given to a patient who is asked not to fill it unless symptoms do not improve in a few days—is conceptually flawed and should be avoided. Delayed antibiotic prescriptions are usually given for antibiotic-inappropriate diagnoses (e.g., viral infections); they ignore the natural history of acute respiratory infections, which are self-limited and generally last from 5 to 14 days; they put the burden of clinical decision-making on patients; and they send a confusing, mixed message to patients about the appropriateness of antibiotics for respiratory infections.

NONSPECIFIC UPPER RESPIRATORY INFECTION ("THE COMMON COLD")

DEFINITION AND ETIOLOGY

Nonspecific URI, or the common cold, is a respiratory tract infection in which no single symptom predominates. Nonspecific URI is most commonly caused by respiratory viruses that are acquired through direct contact with infected individuals, contaminated surfaces, and large and small respiratory droplets. The most common viral causes of nonspecific URIs are rhinoviruses (well over 100 serotypes; **Chap. 199**), coronaviruses, parainfluenza virus, respiratory syncytial virus, influenza virus **(Chap. 199)**, adenovirus (57 serotypes; **Chap. 199**), metapneumovirus, and bocavirus **(Chap. 199)**. Making a specific viral diagnosis is not practical, cost-effective, or necessary. Multiplex panels of reverse transcription polymerase chain reaction are available but may be overly sensitive, as prior recent infection can cause false-positive results. Although the diagnosis is usually obvious, clinicians diagnosing a nonspecific URI should also consider influenza **(Chap. 200)**, measles (cough, coryza, and conjunctivitis; **Chap. 205**), acute HIV infection (in which sore throat and rash often predominate; see below and **Chap. 202**), and COVID-19 **(Chap. 199)**.

Individual susceptibility to nonspecific URIs depends on prior exposure, immunity, general health, genetics, microbiome-related factors, and mental health and social factors, including stress. Prior exposure leads to immunity to specific rhinoviruses and adenoviruses, but the number of serotypes makes reinfection likely. Immunity to non-COVID-19 coronaviruses, parainfluenza virus, respiratory syncytial virus, and metapneumoviruses is generally weak or of short duration.

SYMPTOMS AND SIGNS

Common respiratory viruses have incubation periods of 2–8 days after exposure. Symptoms generally begin gradually and include nasal fullness or obstruction, rhinorrhea, sore throat, laryngitis, lymphadenopathy, cough, and low-grade fever. Patients may have myalgias, but this feature usually is not as prominent as it is in influenza. Epistaxis is common with frequent nose blowing.

On physical examination, findings vary, but patients may have conjunctivitis, pharyngeal erythema, pharyngeal exudates, or pharyngeal cobblestoning. Depending on the phase of illness, the nasal mucosa may be pale, boggy, or red and swollen. Nasal mucus can range from watery to purulent. On auscultation, the lungs may be clear, or the patient may have diffuse wheezing or bronchial breath sounds consistent with a viral infection. Symptoms usually last 5–10 days but often last up to 14 days.

TREATMENT OF NONSPECIFIC UPPER RESPIRATORY INFECTION

For adults and older children, treatment of nonspecific URI is symptom-based. Fever, myalgias, and sore throat can be treated with acetaminophen or a nonsteroidal anti-inflammatory drug (NSAID) such as ibuprofen. Rhinorrhea can be treated with ipratropium bromide. Nasal congestion can be

managed with nasal decongestants such as oxymetazoline (two sprays into each nostril twice a day for up to 5 days) or systemic decongestants such as pseudoephedrine. Products that combine a decongestant with analgesics, antihistamines, or both help relieve symptoms. Although supporting data are weak, cough may be relieved with dextromethorphan or benzonatate (Tessalon Perles). Opioids, while effective at relieving cough, are associated with somnolence, dysphoria, constipation, and addiction.

For children <6 years old, cough and cold medicines should not be prescribed, recommended, or used because of the risks of adverse effects. Honey can help soothe a sore throat for children >1 year old. Cool-mist humidifiers may help with breathing, and saline nasal drops and bulb suctioning can help with nasal congestion.

Patients need to be informed that symptoms generally peak early but can last for up to 14 days; that they are infectious as long as they have symptoms; and that they should rest and drink plenty of fluids to avoid dehydration. Red flags for which patients should seek care include a fever of >102°F, chest pain (other than from a pulled muscle), shortness of breath, dizziness, confusion, new ear or sinus pain, and symptoms lasting >14 days. Although nonspecific URI can be complicated by otitis media and bacterial sinusitis, for an individual patient, an antibiotic is more likely to cause an adverse reaction than to prevent complications.

Other remedies that are ineffective, of questionable benefit, or associated with significant adverse effects include echinacea, zinc, inhaled steam, vitamin C, vitamin D, garlic, antihistamines, Chinese medicinal herbs, intranasal glucocorticoids, *Pelargonium sidoides* herbal extract, saline nasal irrigation, and antiviral drugs.

EAR PAIN

Ear pain is most commonly caused by otitis externa and otitis media. In adults, otologic disease is almost always associated with hearing changes. At >50 years of age, temporal arteritis should be considered in patients who have headache, malaise, weight loss, fever, anorexia, and a normal ear exam. Head and neck cancers should be considered in persons with a history of smoking and alcohol use. In children, the presence of a foreign body should be considered.

Ear pain can also result from other causes of local infection, inflammation, trauma, or tumors or can be referred. Innervation of the ear and surrounding areas includes cranial nerves V, VII, IX, and X and cervical nerves C2 and C3. Neuropathic and myopathic pain syndromes (e.g., trigeminal neuralgia) can cause ear pain. Ramsay Hunt syndrome (herpes zoster oticus) **(Chap. 441)** and Bell's palsy **(Chap. 441)** are both associated with ear pain.

Dental pathology can cause pain that radiates to the ear; caries and abscesses are most common. Bruxism, malocclusion, and temporomandibular disorder may be associated with tenderness in muscular attachments and the temporomandibular joint. Salivary gland pathology and cervical adenopathy can cause pain that radiates to the ear.

Sinusitis, tonsillitis, and pharyngitis cause pain that can radiate to the ear via cranial nerve IX. Gastroesophageal reflux disease **(Chap. 321)** is often associated with ear symptoms. Myocardial infarction can cause ear pain via cranial nerve X.

Relapsing polychondritis **(Chap. 366)** is a rare condition associated with recurrent, sometimes bilateral, erythematous, or violaceous swelling of the auricle (sparing the earlobe). Inflammation from relapsing polychondritis can involve nasal septal, laryngeal, or respiratory cartilage and can cause ocular inflammation, audiovestibular damage, and nonerosive seronegative inflammatory arthritis.

OTITIS EXTERNA

Etiology and Clinical Manifestations

Otitis externa is an inflammation or infection of the external auditory canal manifesting as pain, redness, swelling, aural discharge, and hearing impairment. It is often associated with bacterial infection (frequently by *Pseudomonas aeruginosa* or *Staphylococcus aureus*), but fungi like *Aspergillus* or *Candida* can be implicated.

Otitis externa is most common among preteen and teenage children. Risk factors for otitis externa include swimming (with the resulting condition referred to as "swimmer's ear," which is more common in the summer), mechanical trauma (from cotton swabs or hearing aids), narrow ear canals,

cerumen obstruction, eczema, and psoriasis. Classic swimmer's ear is associated with bacterial infection. Physical exam is notable for pain on movement of the auricle or tragus and an external auditory canal that is erythematous, edematous, inflamed, and sometimes coated with exudate on otoscopy. In contrast, fungal otitis externa often manifests with pruritus and ear discharge but without much pain.

Otitis externa can co-occur with otitis media. Preauricular, mastoid, parotid, or cervical lymphadenopathy may be present. AOM with tympanic membrane rupture (see below) can be associated with ear discharge and debris in the ear canal but (unlike otitis externa) without sensitivity to movement of the auricle.

Malignant Otitis Externa

Malignant otitis externa is a potentially life-threatening form of otitis externa that involves the temporal bone and occurs in patients with diabetes or other types of immunosuppression, often in older adults. Patients may have fever. Progression of malignant otitis externa can affect cranial nerve VII, IX, XI, or XII.

TREATMENT OF OTITIS EXTERNA

Analgesia should be provided with acetaminophen or an NSAID. The mainstay of treatment is one or more topical antibacterial drugs with a glucocorticoid for 7–10 days. Polymyxin B–neomycin–hydrocortisone is often used but should be avoided in patients with tympanic membrane perforation because of ototoxicity. Ciprofloxacin–hydrocortisone is an alternative.

Topical aluminum acetate may be as effective as a topical antibacterial–glucocorticoid regimen. For patients whose condition does not improve within 2–4 days with topical treatment, ear wicks or gauze impregnated with or soaked in anti-infective agents can be placed. Ineffective treatments include oral antibiotics and topical antifungals. Otitis externa frequently recurs; its recurrence may be prevented with periodic acetic acid or aluminum acetate drops.

For malignant otitis externa, oral antipseudomonal antibiotics are often prescribed. Patients sometimes require IV pain medication, fluids, or other antimicrobials.

ACUTE OTITIS MEDIA

Epidemiology and Etiology

AOM—for which patients almost always present within days—is predominantly a disease of children, with incidence peaking at 6–24 months of age. By age 6, ~60% of children will have had an episode of AOM. Younger children appear to be susceptible because of a shorter, more horizontal eustachian tube that more easily accumulates fluid than it does in older children and adults and because their immune system is still developing.

AOM is caused by a viral URI leading to edema and inflammation of the nasopharynx and eustachian tube, collection of fluid, and infection by bacteria that colonize the nasopharynx. Viruses isolated include respiratory syncytial virus, rhinoviruses, enteroviruses, coronaviruses, influenza virus, adenoviruses, and human metapneumovirus. The bacteria most commonly isolated are *Streptococcus pneumoniae*, nontypeable *Haemophilus influenzae*, and *Moraxella catarrhalis*.

Symptoms and Signs

Symptoms of AOM include ear pain, fever, irritability, otorrhea, and anorexia. Physical examination may be notable for a bulging, inflamed, cloudy tympanic membrane, with obscured landmarks, and immobility of the membrane on pneumatoscopy, the Valsalva maneuver, or swallowing while holding the nose shut. (An immobile tympanic membrane is also indicative of perforation, old middle-ear adhesions, a blocked auditory tube, or the presence of middle-ear fluid.) Patients have conductive hearing loss. Severe signs and symptoms include moderate to severe otalgia, otalgia lasting at least 2 days, and a temperature of >102.2°F.

AOM should be diagnosed in children with moderate to severe bulging of the tympanic membrane or new-onset otorrhea (not due to otitis externa). With mild bulging of the tympanic membrane, AOM can also be diagnosed if the patient has had symptoms for <48 h or if there is intense erythema of the tympanic membrane. AOM should *not* be diagnosed in children who do not have middle-ear effusion.

TREATMENT OF ACUTE OTITIS MEDIA

Pain from AOM should be treated with NSAIDs or acetaminophen, which are effective for mild to moderate pain. Topical agents like benzocaine, procaine, or lidocaine may provide some additional, brief benefit beyond that offered by NSAIDs or acetaminophen.

In up to 80% of children, AOM resolves without antibiotics. Indications for antibiotic treatment in children include an age of <6 months, bilateral ear findings in children 6 months to 2 years old, otorrhea in children >6 months old, and—in children of all ages—ear findings with severe otalgia, ear pain for >48 h, or a fever of >102.2°F **(Table 35-1)**.

TABLE 35-1

Indications for Antibiotic Treatment of Acute Otitis Media

AGE	INDICATION
<6 months	Antibiotic treatment reasonable for all
6 months to 2 years	Bilateral ear findings
≥6 months	Otorrhea
>2 years	Symptoms worsening or not improving within 48–72 h
All ages	Ear findings with severe otalgia, otalgia lasting at least 2 days, or temperature of >102.2°F

The benefits of antibiotics are modest and are offset by adverse effects. Antibiotics do not result in early resolution of pain but do decrease pain by day 2 or 3 (number needed to treat, 20 patients treated with antibiotics for 1 patient to have decreased pain by day 2 or 3). More children who receive antibiotics have vomiting, diarrhea, and rash (number needed to harm, 14 patients treated with antibiotics for 1 to have vomiting, diarrhea, or rash). Severe complications like mastoiditis are rare, and the number needed to treat to prevent a case of mastoiditis is ~5000 (i.e., 5000 otitis media patients treated with antibiotics to prevent 1 case of mastoiditis). The American Academy of Family Physicians recommends not routinely prescribing antibiotics for otitis media in children 2–12 years old who have nonsevere symptoms and for whom the observation option is reasonable.

The antibiotic of choice for AOM is high-dose amoxicillin (90 mg/kg per d, up to 3 g). Alternatives include cefdinir, cefuroxime, cefpodoxime, or IM ceftriaxone. If the patient has received amoxicillin in the prior 30 days, clinicians should prescribe amoxicillin/clavulanate (90/6.4 mg/kg per d) in two divided doses. The duration of antibiotic treatment is 10 days for children <2 years old or children with severe symptoms; 5–7 days for children 2–5 years old with mild to moderate AOM; and 5 days for children ≥6 years old with mild or moderate symptoms.

If a patient's condition is not better after 48–72 h of treatment, the antibiotic regimen should be changed to amoxicillin/clavulanate, a second- or third-generation oral cephalosporin, or IM ceftriaxone for 3 days. If, despite a change in antibiotics, the patient's condition still does not improve, that patient should be referred to a specialist. Middle-ear effusions are present in 60–70% of children with AOM; these should resolve over 3 months. Tympanostomy tubes should be considered for recurrent AOM (i.e., three episodes in 6 months or four episodes in 1 year). Mastoiditis is a rare complication of AOM that is suggested by postauricular tenderness, a postauricular mass, or protrusion of the ear lobe.

In adults, AOM is rare and there is little high-quality evidence to guide treatment. For adults, it remains important to differentiate AOM from OME, but AOM is generally treated with antibiotics, regardless of bilaterality or otorrhea. Amoxicillin is the drug of choice. Adults should also be treated with decongestants and analgesics. Adults with more than two episodes in a year or persistent effusion should be referred to an otolaryngologist.

OTITIS MEDIA WITH EFFUSION

Definition and Etiology

OME, also called serous otitis media, occurs when there is fluid in the middle ear but no acute infection. Most patients with OME are young children;

>60% of cases occur in children <2 years old. Many children have recurrent episodes.

OME is most often a sequela of a viral infection causing AOM, but it can also be caused by allergies. In addition to allergies, predisposing factors include craniofacial abnormalities, gastroesophageal reflux, and enlarged adenoids.

Symptoms and Signs

The most common symptoms are decreases in sound conduction and hearing. Children with OME may exhibit impaired language development or communication difficulties. More rarely, patients complain of intermittent ear fullness or earache, tinnitus, or balance problems. On examination, the tympanic membrane may be translucent or gray with fluid (often colorless or amber), air-fluid levels, or bubbles behind the membrane. There is a loss of the light reflex. The tympanic membrane has decreased mobility on pneumatic otoscopy. The evaluation may include audiometry, tympanometry, and, in infants, measurement of auditory brainstem responses.

OME usually resolves spontaneously within 4–6 weeks. If it persists for >3 months, the condition is referred to as chronic OME or chronic serous otitis media.

Cholesteatomas are accumulations of epithelium or keratin in the middle ear that can enlarge, perforate the tympanic membrane, envelop the ossicles, or destroy surrounding tissue. Cholesteatomas can cause labyrinthitis, hearing loss, cranial nerve palsies, vertigo, meningitis, extradural or brain abscess, and lateral sinus thrombophlebitis.

TREATMENT OF OTITIS MEDIA WITH EFFUSION

OME is treated with myringotomy with tympanostomy tube insertion. For young children with nasal obstruction or recurrent infection, adenoidectomy may be considered. Medications, including antihistamines, glucocorticoids, or antibiotics, do not reliably help. Children at risk for speech or language delay may need earlier referral for more aggressive treatment.

ACUTE MASTOIDITIS

Etiology

Acute mastoiditis is a serious infection with significant morbidity despite antibiotic and surgical treatment. This condition is most common among children <2 years old but can occur at any age. Acute mastoiditis is often a complication of AOM but may develop without clinically apparent, prior AOM. In older children with acute mastoiditis, clinicians should suspect cholesteatoma.

The pathogenesis of mastoiditis involves spread of organisms from the middle-ear spaces through the aditus ad antrum to the mastoid air cells. *Incipient* mastoiditis consists of fluid within the mastoid air cells, without bony destruction of the bony septa, and can progress to *coalescent* mastoiditis, with destruction of the bony septa. Acute mastoiditis often causes subperiosteal abscess laterally. The organisms most commonly involved in mastoiditis are *S. pneumoniae*, *Streptococcus pyogenes, H. influenzae, S. aureus* (including methicillin-resistant *S. aureus* [MRSA] strains), and *P. aeruginosa*.

Symptoms and Signs

Symptoms of acute mastoiditis include ear pain, fever, lethargy, or fussiness despite adequate treatment of AOM. Patients—especially those with subperiosteal abscess—may have postauricular erythema, tenderness, warmth, fluctuance, and protrusion of the auricle. Otoscopic examination most often yields findings of AOM and may show superoposterior protrusion of the external auditory canal. Complications of mastoiditis include facial nerve palsy, labyrinthitis, skull osteomyelitis, temporal lobe abscess, cerebellar abscess, meningitis, epidural abscess, subdural abscess, venous sinus thrombosis, or Bezold's abscess (an abscess medial to the sternocleidomastoid that tracks into the deep cervical fascia).

Evaluation

Laboratory evaluation reveals elevation of inflammatory markers and white blood cells with neutrophilia. Imaging is not necessary in children with a classic history and presentation but may be required if there is concern about complications or severity. CT may show disruption of bony septations, fluid, mucosal thickening, periosteal thickening, disruption of the periosteum, or subperiosteal abscess. MRI with gadolinium permits better

visualization of abscesses and vascular problems.

Differential Diagnosis

The differential diagnosis of acute mastoiditis includes cellulitis, otitis externa, postauricular lymphadenopathy, perichondritis, and tumors, including rhabdomyosarcoma, Ewing sarcoma, and myofibroblastic tumor.

TREATMENT OF MASTOIDITIS

Patients with mastoiditis should be admitted to the hospital and treated with IV antibiotics and myringotomy, with or without tympanostomy tubes; if there is no improvement within 48 h, mastoidectomy should be undertaken. Tympanostomy or myringotomy samples or subperiosteal abscess drainage should be sent for culture and sensitivity testing. Depending on complications, additional drainage and surgical procedures may be necessary.

Empirical IV antibiotic therapy for children without recurrent AOM or recent antibiotic treatment consists of vancomycin (if there is concern about antibiotic-resistant *S. pneumoniae* or MRSA) or a cephalosporin (e.g., cefepime or ceftazidime). Patients with recurrent AOM or recent antibiotic treatment should be given vancomycin plus an antipseudomonal penicillin. Culture and sensitivity results will guide antibiotic changes. IV antibiotic therapy should be continued for 7–10 days, and patients should complete a 4-week course of oral antibiotics.

SINUS SYMPTOMS

Sinus symptoms are commonly due to respiratory viruses. These symptoms are considered acute if they last <4 weeks, subacute if they last 4–12 weeks, and chronic if they last ≥12 weeks. Beyond sinus infection, the differential diagnosis of rhinitis includes the common cold, allergic rhinitis **(Chap. 352)**, vasomotor rhinitis, rhinitis medicamentosa due to topical decongestants, drug-induced rhinitis (e.g., due to aspirin, ibuprofen, or beta blockers), autoimmune disease (e.g., granulomatosis with polyangiitis), and cerebrospinal fluid leak. Pain over the sinuses can be caused by headaches **(Chap. 430)**, facial pain syndromes, temporomandibular disorder **(Chap. 36)**, and dental pathology. Gastroesophageal reflux can cause referral of symptoms to the sinuses. Patients who have uncontrolled diabetes or are otherwise immunocompromised can have rapidly progressing invasive fungal infections **(Chap. 211)**. More indolent fungal infections should be considered in the event of recurrent or nonresolving sinusitis. In children, it is important to consider the presence of a foreign body as a cause of sinus symptoms.

ACUTE SINUSITIS

Definition and Etiology

Sinusitis is an inflammation of the paranasal sinuses; *rhinosinusitis* also involves the nasal passages. The majority of acute sinusitis cases are caused by respiratory viruses. A diagnosis of sinusitis is a major reason for unnecessary antibiotic prescribing in adults: although <2% of sinusitis episodes are due to bacteria (most often *S. pneumoniae, H. influenzae,* or *M. catarrhalis*), antibiotics are prescribed at >70% of office visits for sinusitis. According to guideline criteria, no more than 50% of adults—and probably closer to 20%—meet the criteria for antibiotic prescribing.

Symptoms and Signs

Sinusitis symptoms commonly include purulent nasal discharge, facial congestion or fullness, and facial pain or pressure. Other symptoms include fever; hyposmia or anosmia; ear pain, pressure, or fullness; postnasal drip; halitosis; maxillary toothache; cough; and fatigue. Risk factors for developing sinusitis include an age of 45–65 years, smoking, asthma, air travel, and allergies.

On physical examination, direct rhinoscopy reveals excess mucus or purulence. Patients may have tenderness over the maxillary sinuses and, in severe cases, erythema and swelling of the maxilla. Sinus transillumination is not accurate in diagnosing sinusitis.

Complications

Complications from sinusitis can be dramatic but are extremely rare. These complications may include orbital cellulitis, osteomyelitis, meningitis, intracranial abscesses, and cavernous sinus thrombosis. New symptoms that might indicate a sinusitis complication include confusion, unilateral

weakness, proptosis, limited ocular movements, and acute vision changes.

RECURRENT ACUTE SINUSITIS

Patients who have four or more episodes of acute sinusitis in a year, without signs or symptoms between episodes, are said to have recurrent acute sinusitis.

INVASIVE FUNGAL SINUSITIS

Invasive fungal sinusitis may develop in immunocompromised patients, such as those with uncontrolled diabetes or transplant recipients, and should be considered an emergency. Invasive fungal sinusitis is caused by Mucorales fungi or *Aspergillus* **(Chap. 217)**. Patients may appear to have a rapidly progressive case of rhinosinusitis, with facial pain and pressure, headaches, and fever followed within days by cranial nerve involvement, orbital swelling, cellulitis, proptosis, chemosis, and ophthalmoplegia. Patients may be critically ill. Evaluation should include nasal endoscopy with biopsy and imaging with gadolinium-enhanced MRI as the preferred modality.

NOSOCOMIAL SINUSITIS

Nosocomial sinusitis occurs in critically ill patients, often those who are nasotracheally intubated. Nosocomial sinusitis should be suspected in hospitalized patients who have fever without another identifiable cause.

TREATMENT OF ACUTE SINUSITIS

All patients with acute sinusitis should be counseled about symptom-based treatments, which may include decongestants, analgesic/antipyretics, nasal saline, or intranasal glucocorticoids. Intranasal decongestants (e.g., oxymetazoline, two sprays in each nostril twice a day for no more than 5 days) and oral decongestants (e.g., 12-h pseudoephedrine [120 mg] during the day) relieve pain, pressure, and rhinorrhea. Analgesics and antipyretics like acetaminophen or NSAIDs (e.g., ibuprofen), nasal saline spray, and nasal washes provide relief. Intranasal glucocorticoids may help, particularly for patients with an allergic cause of sinusitis. Because patients may be accustomed to receiving antibiotics, provision of a clear explanation, symptom-based treatments, and reasons for reconsultation are important. Red flags for which patients should reconsult include recurrent fever of >102°F, sinus symptoms that worsen after initial improvement, and rapid worsening of facial pain that becomes persistent, as well as any other concerning symptoms.

Antibiotic prescribing criteria for sinusitis are based on symptoms **(Table 35-2)**. Only patients with persistent, severe, or worsening symptoms, especially those who have already used decongestants and analgesics for 2–4 days, meet the criteria for antibiotic prescribing. The antibiotic of choice is amoxicillin/clavulanate (875 mg/125 mg bid for 7 days). Amoxicillin (875 mg PO bid for 7 days) is an alternative. For patients with mild penicillin allergies, cefuroxime is a reasonable choice. For those with severe penicillin allergies, doxycycline is a reasonable alternative. Macrolides are specifically not recommended for sinusitis because of high rates of macrolide-resistant *S. pneumoniae.*

TABLE 35-2

Indications for Antibiotic Treatment of Acute Sinusitis

INDICATION	DEFINITION
Persistent	Symptoms lasting ≥10 days
Severe	Fever of >102°F and either purulent nasal discharge or nasal pain for at least 3–4 consecutive days
Worsening	New fever, headache, or increase in nasal discharge following an upper respiratory tract infection that lasted for 5–6 days and was initially improving

Note: In typical populations, roughly 20% and no more than 50% of adults with sinusitis will meet the criteria for antibiotic prescribing.

Patients who meet the criteria for antibiotic prescribing should show signs of improvement after 3–5 days of therapy. If not, second-line regimens include amoxicillin/clavulanate (2000 mg/125 mg bid for 7 days) or levofloxacin, although fluoroquinolones are associated with dysglycemia, neuropathy, and tendon and aortic rupture. For patients whose condition still is not improving after 3–5 days of treatment with a second-line antibiotic or in whom a complication or an alternative diagnosis is suspected, clinicians should consider referral to an otorhinolaryngologist and/or the performance of imaging tests. The imaging modality of choice is noncontrast CT. Patients with recurrent acute sinusitis may benefit from nasal culture during episodes; imaging between episodes to identify predisposing anatomic abnormalities; and allergic or immunologic evaluation.

Patients with acute fungal sinusitis should be treated with IV antifungal agents and often require surgical debridement. Patients with nosocomial sinusitis should have precipitating factors (e.g., nasotracheal intubation) addressed and should be empirically treated with broad-spectrum antibiotics until culture and susceptibility results are available.

CHRONIC SINUSITIS

Definition and Etiology

Chronic sinusitis is defined as inflammation of the paranasal sinuses that lasts >12 weeks. Chronic sinusitis is primarily an inflammatory disease and can also be associated with acute or chronic infection or allergic, structural (e.g., deviated nasal septum or polyps), and immunologic etiologies. Repeated viral infections may lead to chronic sinusitis. Bacterial colonization or chronic infection plays a role in some cases of chronic sinusitis. *S. aureus* and gram-negative bacteria are commonly identified. Commonly involved allergens and irritants are dust mites, mold, tobacco smoke, occupational factors, and other airborne toxins. Functional or immunologic problems can include impaired mucociliary clearance (e.g., due to cystic fibrosis) or immunodeficiency due to acquired conditions or medications. Chronic sinusitis often coexists with allergic rhinitis and asthma.

Symptoms and Signs

Cardinal symptoms of chronic sinusitis are facial pain or pressure, nasal discharge or postnasal drip, congestion, and hyposmia or anosmia. Associated symptoms may include fatigue, malaise, ear pressure, hoarseness, and cough. The diagnosis of sinus inflammation must be confirmed with anterior rhinoscopy, nasal endoscopy, or imaging because up to 40% of patients with chronic sinus symptoms do not have mucosal changes evidencing disease.

In practical terms, chronic sinusitis can be divided into three main types (in decreasing order of frequency): (1) chronic sinusitis without polyps, (2) chronic sinusitis with polyps, and (3) allergic fungal sinusitis. In general, chronic sinusitis without polyps is more common among women, develops in childhood and young adulthood, is characterized by presentations with facial pain, and is often due to T_H1 lymphocyte predominance associated with bacterial infection or colonization. Chronic sinusitis with polyps is more common among men; develops in adulthood; is characterized by presentations with decrease or loss of smell, asthma, or aspirin sensitivity **(Chap. 287)**; and is often due to T_H2 lymphocyte predominance associated with eosinophilic inflammation, asthma, or aspirin sensitivity. Allergic fungal rhinosinusitis is also associated with polyp formation; typically occurs in patients in their 20s and 30s who are from warm, humid regions and who have other atopic diseases; and is associated with IgE-mediated allergy and eosinophils **(Chap. 217)**. The mucus in allergic fungal rhinosinusitis is classically greenish-brown, has a peanut butter–like consistency, and includes viable hyphae from *Aspergillus* or other fungal species. Allergic fungal rhinosinusitis is resistant to medical treatments.

Evaluation

On anterior rhinoscopy, polyps are seen as white, gray, tan, or yellow translucent growths in the middle meatus. The imaging modality of choice is noncontrast CT. Allergic fungal rhinosinusitis may be unilateral; however, unilateral symptoms or polyps on exam or imaging, especially if associated with bloody discharge, should raise concern about tumors.

TREATMENT OF CHRONIC SINUSITIS

Treatment includes avoidance of identifiable triggers such as allergens, smoke, and irritants. Saline sprays and washes provide symptom relief, and higher-volume saline washes are probably more effective. Intranasal glucocorticoids, including mometasone and fluticasone sprays or higher-potency and higher-volume budesonide rinses, are mainstays of treatment, especially for chronic sinusitis with polyps. Intranasal glucocorticoids reduce polyp size. Oral administration of glucocorticoids for 2–3 weeks is sometimes effective against chronic sinusitis that is unresponsive to intranasal steroids—

again, especially for patients with polyps. Intranasal or systemic antihistamines may help patients whose illness has an allergic component. Likewise, leukotriene antagonists like montelukast may help.

Although antibiotics are frequently prescribed for 2–4 weeks to patients with chronic sinusitis, there is little evidence that these drugs are effective. Evidence of modest quality supports the use of 3 months of macrolide treatment for patients who have chronic sinusitis without polyps. Antifungal agents have not shown benefit against any subtype of chronic sinusitis. Decongestants should be used only sparingly and briefly.

Endoscopic sinus surgery improves quality of life in patients who have had inadequate responses to medical therapy. Patients with more limited, focal disease may more reliably have better results. The goals of surgery are to remove polyps from the nasal cavity and paranasal sinuses. For patients with allergic fungal rhinosinusitis, medical therapy is classically ineffective, surgery produces good results, and patients should be treated with perioperative glucocorticoids. In children, adenoidectomy may be effective in some cases. In the future, immune endotyping may allow selection of more individualized biological treatments.

SORE THROAT AND NECK PAIN

Sore throat is not synonymous with pharyngitis and can also be caused by submandibular space, retropharyngeal and peritonsillar abscesses, thyroiditis, gastroesophageal reflux, tumors, and postnasal drainage.

Acute pharyngitis, in which symptoms are generally present for days, is most often caused by respiratory viruses; is often caused by group A β-hemolytic streptococci (GAS); and can be caused by other bacteria (including *Neisseria gonorrhoeae*), Epstein-Barr virus (EBV), and HIV. On physical examination, pharyngeal erythema is associated most commonly with viral infections, including the common cold and influenza. Pharyngeal exudate should not be confused with *Candida* infection, which looks like cottage-cheese, can be scraped off, and leaves a bleeding surface, or leukoplakia, which cannot be scraped off. History and exam findings may help differentiate sore throat and pharyngitis of various etiologies **(Table 35-3)**.

TABLE 35-3

Clinical Findings That Suggest Various Forms of Nonstreptococcal Pharyngitis

CLINICAL FINDING(S) OR BEHAVIORAL FACTOR	SUSPECTED DIAGNOSIS
Scarlatiniform rash	Group A β-hemolytic streptococci or *Arcanobacterium haemolyticum*
Cough and otitis media	*Haemophilus influenzae*
Sex between men with associated urogenital symptoms, fellatio between a woman and a man who has current urogenital symptoms, persistent sore throat unresponsive to penicillin	*Neisseria gonorrhoeae*
Travel to endemic areas, pseudomembrane on examination	*Corynebacterium diphtheriae*
Persistent sore throat with bronchopulmonary symptoms	*Mycoplasma pneumoniae*
Marked adenopathy (especially that involving posterior cervical or auricular nodes), splenomegaly, palatine petechiae, gelatinous uvula	Acute infectious mononucleosis
New sexual partner in the previous month; fever, rash, myalgias, headache	Acute HIV infection

STREPTOCOCCAL PHARYNGITIS

GAS is the only common cause of sore throat that should be treated with antibiotics. The principal goal in the evaluation of adults with sore throat is to

identify patients likely to have GAS pharyngitis, or "strep throat." Prompt antibiotic treatment of adults likely to have strep throat has the potential to reduce symptoms, prevent the spread of disease, and reduce suppurative complications (e.g., peritonsillar abscess). Nonsuppurative complications are rare. In developed countries, the prevalence of rheumatic fever **(Chap. 148)** is extremely low, and antibiotic treatment does not prevent poststreptococcal glomerulonephritis **(Chap. 148)**.

Most patients with non-GAS pharyngitis have various forms of viral pharyngitis and do not require antibiotics. Nevertheless, clinicians prescribe antibiotics to a majority of adults with sore throats. By using a simple clinical scoring algorithm, clinicians can predict the presence or absence of GAS with sufficient accuracy and avoid prescribing antibiotics to patients who are unlikely to have strep throat. Although there is a role for testing (see "Evaluation," below), most adults with sore throat do not need to have a GAS test.

About 10% of adults with sore throat are infected with GAS. Among children with sore throat, the prevalence of GAS can be as high as 35%, with rates peaking from 5 to 15 years of age. The prevalence of GAS is higher in winter and early spring. The risk of streptococcal pharyngitis is elevated among health care and child care workers, teachers, parents of young children, and patients exposed to individuals with strep throat. Clinicians need to be aware of local outbreaks of GAS infection, particularly in military and institutional settings, where the prevalence of GAS and the risk of acute rheumatic fever may be elevated.

Evaluation

The Centor criteria consist of four findings, each of which is assigned 1 point: (1) history of fever, (2) absence of cough, (3) tender anterior cervical lymphadenopathy, and (4) tonsillar exudate or swelling. The Centor criteria are easy to assess and accurately stratify adult patients with suspected streptococcal pharyngitis. Patients with no points have a 2% probability of being infected with GAS, whereas those with 4 points have a probability of 41% **(Table 35-4)**. The Centor criteria have an area under the curve of 0.79. Other clinical decision algorithms similar to the Centor criteria may not perform as well, are not as simple, or have not been as rigorously evaluated.

TABLE 35-4

The Centor Criteria and the Probability of Streptococcal Pharyngitis for Adults[a]

NO. OF CRITERIA MET[b]	POSTEVALUATION PROBABILITY (%)	RECOMMENDATION
0	2	No test, no antibiotic
1	3	No test, no antibiotic
2	8	Rapid test
3	19	Rapid test
4	41	Empirical antibiotic treatment or rapid test

[a]Assuming a pretest probability of strep throat for adults of 10%. [b]The criteria are (1) a history of fever, (2) an absence of cough, (3) tender anterior cervical lymphadenopathy, and (4) tonsillar swelling or exudate. Each criterion gets 1 point. Roughly 40–60% of adults will meet no criteria or one criterion; ~20% will meet the criteria for antibiotic prescribing.

If the test/no treatment threshold is set at 5%, for a GAS prevalence of ~10%, adults meeting no criteria or only one Centor criterion have a probability of GAS pharyngitis so low that they should neither be tested nor be treated with an antibiotic. Adults meeting two or three Centor criteria have an intermediate probability of GAS pharyngitis; they should have a rapid antigen test performed, and the results should guide antibiotic treatment. For adults meeting four Centor criteria, it is reasonable either to perform a rapid test or to institute empirical antibiotic treatment. However, some guidelines recommend—and some ambulatory quality measures require—a GAS test to be associated with antibiotic prescribing in adults, regardless of the number of Centor criteria met.

In children, the Centor criteria are less specific, and streptococcal pharyngitis should be confirmed with testing. Children who have signs of pharyngitis without signs of viral infection (conjunctivitis, runny nose, cough, hoarseness, nonexudative oral lesions) should have testing performed.

Outside of the United States, because complications are rare and even streptococcal pharyngitis is self-limited in the vast majority of cases, some guidelines do not recommend use of rapid GAS testing or routine antibiotic treatment of sore throat.

Clinicians should have a lower threshold for diagnosing and treating GAS pharyngitis in patients with a history of acute rheumatic fever, patients with documented streptococcal exposure in the past week, patients who live in a community with a current strep throat epidemic, and patients who are diabetic or otherwise immunocompromised.

RAPID STREP TESTS

Rapid GAS-specific antigen tests have a sensitivity of ~80% and a specificity of ~95%. Results are available within minutes and can be used to make therapeutic decisions before the patient leaves the office. Improper collection technique can adversely affect the sensitivity of rapid strep tests: clinicians should rub the tonsils and pharynx, touching any areas where exudate or ulceration are present.

THROAT CULTURES

A single-swab throat culture has a sensitivity of ~85–90%, as defined by isolation of GAS on a second swab. A throat culture can also be falsely positive for true infection: some patients with a culture positive for GAS may be only uninfected carriers, as defined by their failure to exhibit a fourfold increase in antibodies to GAS—the gold standard test. Among adults and children seeking medical care for a sore throat, test specificity may be as low as 50–70% because of patients who do not exhibit serologic evidence of infection. Throat cultures are not recommended for the routine evaluation of adults with sore throat. The modest gain in sensitivity over rapid testing is outweighed by the 24- to 48-h delay in test results, with a consequent delay in the symptomatic relief associated with antibiotic treatment.

Indiscriminate strep testing in adults with sore throat or respiratory symptoms should be discouraged. Rapid strep tests and culture do not differentiate between patients who have true infection and those who are carriers of GAS (with carriage rates as high as 20% among schoolchildren and ~5% among adolescents and young adults). In adults who meet no Centor criteria or only one criterion—40–60% of adults with pharyngitis—a positive test is highly likely to be falsely positive and/or to represent GAS carriage.

Complications

Complications of streptococcal pharyngitis are rare but include acute rheumatic fever **(Chap. 148)**, poststreptococcal glomerulonephritis **(Chap. 148)**, scarlet fever **(Chap. 148)**, sinusitis, peritonsillar abscess, and other invasive GAS infections.

TREATMENT OF STREPTOCOCCAL PHARYNGITIS

All patients with pharyngitis—nonstreptococcal and streptococcal—should receive analgesics (acetaminophen or NSAIDs). Saline gargles, humidification, soft foods, and tea with honey soothe a painful throat.

Penicillin is the antibiotic of choice for streptococcal pharyngitis **(Table 35-5)**. Penicillin is a narrow-spectrum, low-cost, and well-tolerated drug to which no GAS isolate has been resistant. Amoxicillin is an acceptable alternative in children as it comes in a palatable liquid form. For patients with mild penicillin allergy, cephalexin and cefadroxil are good alternatives. For patients with severe penicillin allergies, clinicians should prescribe erythromycin, clarithromycin, or clindamycin. Unlike other infections for which emerging evidence supports progressively shorter antibiotic courses, streptococcal pharyngitis requires longer courses (7–10 days), which are more effective.

TABLE 35-5

Antibiotic Treatment of Group A Streptococcal Pharyngitis

ANTIBIOTIC	DOSING
Antibiotic of Choice	
Penicillin	500 mg PO qid or 1000 mg PO bid × 10 days
Alternative for Non-Penicillin-Allergic Patients	
Amoxicillin	500 mg PO bid or 1000 mg qd × 10 days
Alternatives for Non-Anaphylactic Penicillin-Allergic Patients	
Cephalexin	500 mg PO bid × 10 days
Cefadroxil	1 g PO qd × 10 days
Alternatives for Patients with Severe Penicillin Allergy	
Erythromycin	250–500 mg PO qid or 500–1000 mg PO bid × 5 days
Clarithromycin	500 mg PO bid × 5 days
Clindamycin	300 mg PO tid × 10 days

Glucocorticoids (e.g., dexamethasone, 10 mg as a single oral dose) have so far been poorly studied as an adjunctive treatment for sore throat and strep throat and are not recommended. These drugs may result in decreased pain within 24 h but do not decrease school or work absenteeism or relapse rates. Even short courses of steroids are associated with increased rates of sepsis, gastrointestinal bleeding, congestive heart failure, venous thromboembolism, and fracture within 30 days.

Streptococcal and nonstreptococcal pharyngitis should resolve in 3–5 days. Symptoms that should lead patients to seek further care include shaking chills (rigors), neck swelling (beyond lymphadenopathy), trouble swallowing, drooling, or symptoms that persist for >5 days without improvement.

NONSTREPTOCOCCAL PHARYNGITIS

Acute Infectious Mononucleosis

New EBV infection may be the cause of pharyngitis in 1–6% of young adults **(Chap. 194)**. EBV is rarely the cause of pharyngitis in adults >40 years of age. The full-blown acute syndrome, which is present in only about one-fourth of patients with infectious mononucleosis (“mono”), is characterized by a triad of clinical, hematologic, and serologic findings. The clinical presentation is typified by the development over several days of malaise, fever, sore throat, and marked adenopathy that is particularly evident in the cervical lymph nodes. On physical examination, marked adenopathy is virtually always documented and is most specific for mononucleosis when the posterior cervical or posterior auricular nodes are involved. Splenomegaly and exudative pharyngitis with prominent tonsillar swelling, palatine petechiae, and a gelatinous uvula are often noted. The classic hematologic findings are an absolute lymphocyte count of >4000/μL or a relative lymphocyte count of >50% with “atypical” morphologic features in >10% of the lymphocytes. The characteristic serologic finding is the heterophil antibody, which is detectable in only 40% of patients during the first week of illness but in 80–90% of patients by the third week.

Other Bacterial Pharyngitis

Non–group A streptococci (especially group C and group G streptococci), *Mycoplasma pneumoniae*, *Chlamydia pneumoniae*, *N. gonorrhoeae*, and *H. influenzae* have all been associated with sore throat in some studies. Although antibacterial treatment has not been proven to speed the resolution of symptoms and signs of any of these types of nonstreptococcal pharyngitis, antibiotic treatment is indicated if throat cultures from a patient with persistent sore throat yield group C or group G streptococci.

LEMIERRE'S SYNDROME

Lemierre's syndrome consists of septic thrombophlebitis of the internal jugular vein accompanied by metastatic infections, most commonly of the lung but with possible involvement of the joints, bones, liver, meninges, and brain. Lemierre's syndrome is most commonly caused by *Fusobacterium necrophorum*, although it can also be caused by species of *Bacteroides, Eikenella, Streptococcus, Peptostreptococcus,* or other bacterial genera. This syndrome probably occurs predominantly in male patients. Clinicians should consider Lemierre's syndrome in a teenage or young adult patient who has non-GAS pharyngitis that is not resolving, particularly if it is accompanied by rigors, neck pain or swelling, or other extrapharyngeal symptoms.

GONOCOCCAL PHARYNGITIS

N. gonorrhoeae may be the cause of pharyngitis in 1% of adult patients seeking primary care for a sore throat, although gonococcal infection of the pharynx is more often asymptomatic. When symptomatic, pharyngeal gonorrhea may range from mild to severe, with protracted pharyngitis characterized by pain, fever, and pharyngeal exudate. Gonococcal pharyngitis should be suspected in men who have sex with men with associated symptoms of urogenital infection, women who have practiced fellatio with a man with genital gonorrhea, and anyone who has persistent sore throat that has been unresponsive to treatment for presumptive streptococcal pharyngitis.

DIPHTHERIA

Diphtheria, caused by *Corynebacterium diphtheriae,* is endemic in developing countries **(Chap. 150)**. Diphtheria produces only mild pharyngitis beneath its characteristic grayish pseudomembrane.

ACUTE HIV INFECTION

Clinicians should consider acute HIV infection in patients with sore throat, particularly when it is associated with headache, fever, myalgias, lymphadenopathy, anorexia, and rash **(Chap. 202)**. Of patients with acute HIV infection, roughly half have a sore throat. However, in most settings in the United States, only ~1% of patients with viral or mononucleosis-like symptoms have acute HIV infection.

HEAD AND NECK ABSCESSES

Head and neck abscesses are more common among patients with diabetes, who are immunocompromised, and among older adults. Such abscesses are often a complication of infections of the teeth and gums, throat, or salivary ducts; lymphadenitis; ear infections; sinus infections; congenital cysts; and IV drug use. Prompt recognition is important, as head and neck abscesses can cause airway compromise due to edema or mass effect. Head and neck abscesses can follow fascial planes and spread to the mediastinum (where they can cause mediastinitis, pleural effusions, empyema, or pericarditis), the carotid sheath, the skull base, and the meninges. Head and neck abscesses have also been associated with aspiration pneumonia, necrotizing fasciitis, Lemierre's syndrome, and toxic shock syndrome.

Submandibular abscesses generally result from an infected or extracted tooth and can cause Ludwig angina, a swelling of the floor of the mouth that can enlarge and displace the tongue posteriorly.

Peritonsillar abscesses, which may occur predominantly in male patients, generally result from complicated bacterial pharyngitis and present with fever, dysphagia, profound throat pain (necessitating drooling to avoid swallowing saliva), trismus, and "hot potato voice" (inability to articulate, as if patients have hot food in their mouths). Patients are likely to have unilateral palate bulging, often with uvular deviation. Peritonsillar abscesses are caused by viridans group streptococci, β-hemolytic streptococci, *F. necrophorum*, *S. aureus, Prevotella,* and *Bacteroides.*

Retropharyngeal abscesses often present after an antecedent URI in children with sore throat, dysphagia, deep neck pain, neck stiffness, trismus, and drooling. The pharyngeal wall may be displaced, but swelling or abscess may not be apparent on examination. In severe cases, patients may have dyspnea and stridor.

Patients with suspected head and neck abscesses, with the possible exception of patients who have obvious peritonsillar abscesses, should undergo imaging by CT.

TREATMENT OF HEAD AND NECK ABSCESSES

The mainstays of treatment for head and neck abscesses are securing the airway, surgical drainage, and IV antibiotic administration. To secure the airway, mask ventilation or oral intubation may not be effective, and oral fiberoptic intubation or tracheotomy may be necessary. Peritonsillar abscess may be managed with needle aspiration and/or tonsillectomy. Other head and neck abscesses require incision and drainage. The selected IV antibiotics should cover streptococci, anaerobes, and possibly *S. aureus*. Frequently used antibiotics include ampicillin/sulbactam, clindamycin plus ceftriaxone, or meropenem. For some abscesses with adequate source control with incision and drainage, penicillin may be as effective as broader-spectrum agents.

EPIGLOTTITIS

Along with associated dysphagia, odynophagia, hoarseness, and stridor or tachypnea, supraglottitis or epiglottitis must be considered in adults presenting with sore throat. The inflamed and enlarged epiglottis protrudes up into the oropharynx. Patients may extend their neck or lean forward and drool oral secretions to avoid swallowing. Epiglottitis can cause “hot potato voice.” Attempts to examine or swab the posterior pharynx or obtain a culture can provoke laryngospasm and should only be done carefully in a controlled setting. Because obstruction of the airway may become acutely life-threatening, the patient with epiglottitis must be observed in a hospital setting, and examination in an operating room, where an airway can be established immediately by an experienced operator, should be strongly considered. Although not necessary for the diagnosis, a lateral neck radiograph can demonstrate epiglottal swelling referred to as the “thumb sign.”

In adults, conservative therapy under observation is sufficient in most cases, but intubation by an experienced clinician or tracheostomy may become necessary. Treatments also include humidification with nebulized normal saline or humidified oxygen and administration of glucocorticoids, IV antibiotics, and nebulized epinephrine.

H. influenzae, the most common cause of supraglottitis in children, is less common in adults. Other responsible organisms in adults are *S. pneumoniae*, *S. pyogenes*, and *S. aureus*. The *H. influenzae* type b vaccine has led to a dramatic decrease in epiglottitis overall, with large reductions in young children; however, the incidence of supraglottitis and epiglottitis in adults may be increasing.

LARYNGITIS

Laryngitis—inflammation of the larynx and surrounding structures—is most commonly caused by viral URIs. In children, parainfluenza virus can cause croup, or laryngotracheobronchitis, which is characterized by a “barking” cough but can also include laryngitis.

Beyond viruses, laryngitis can be caused in rare cases by bacteria and fungi. Bacterial laryngitis can be a complication of viral laryngitis, occurring about 7 days into the illness. The most common bacteria involved are *S. pneumoniae, H. influenzae,* and *M. catarrhalis.* Fungal laryngitis is probably rarer but should be considered in patients who are immunosuppressed or who have recently been treated with antibacterial drugs.

Noninfectious causes of laryngitis include vocal trauma (e.g., due to yelling, screaming, or loud singing), inhalation injuries, allergies, gastroesophageal reflux disease (laryngopharyngeal reflux), asthma, and pollution. Immunosuppressed patients are at risk for infections with herpesvirus, HIV, and coxsackievirus. Smokers are at elevated risk for malignancy and other infections.

Laryngitis is characterized by a raspy, hoarse, or breathy voice, sometimes progressing to a complete loss of voice. Laryngitis can have associated dry cough and anterior throat pain; patients often feel a need to clear their throats. The physical examination in patients who may have laryngitis should focus on the head, neck, and lungs, but the diagnosis of laryngitis is generally based on history. If visualization of the vocal cords is necessary, indirect examination with a mirror or flexible laryngoscopy usually shows erythema and edema of the vocal cords and surrounding structures.

TREATMENT OF LARYNGITIS

Laryngitis is generally self-limited, usually lasting 3–7 days, but may last up to 14 days. Vocal rest is crucial. Airway humidification and hydration should help. Patients likely to have laryngopharyngeal reflux should avoid gastroesophageal reflux–inducing foods and behaviors and should take antireflux

medications. In randomized controlled trials, antibiotics were not effective in decreasing objective symptoms of laryngitis.

Red flags for emergency evaluation and monitoring include shortness of breath, stridor, dysphagia, odynophagia, drooling, and posturing that could indicate epiglottitis. Referral to an otolaryngologist should be considered for patients who rely on their voice for work, such as singers and teachers. A history of smoking or weight loss should raise suspicion of malignancy. Symptoms lasting >3 weeks should prompt referral to an otolaryngologist or speech specialist.

FURTHER READING

Centor RM, Linder JA: Web exclusive. Annals on call—*Fusobacterium* pharyngitis debate. Ann Intern Med 171:OC1, 2019.

Chua KP et al: Appropriateness of outpatient antibiotic prescribing among privately insured US patients: ICD-10-CM based cross sectional study. BMJ 364:k5092, 2019. [PubMed: 30651273]

Lieberthal AS et al: Clinical practice guideline: The diagnosis and management of acute otitis media. Pediatrics 131:e964, 2013. [PubMed: 23439909]

Rowe TA, Linder JA: Novel approaches to decrease inappropriate ambulatory antibiotic use. Expert Rev Anti Infect Ther 17:511, 2019. [PubMed: 31232615]

Sanchez GV et al: Core elements of outpatient antibiotic stewardship. MMWR Recomm Rep 65:1, 2016. [PubMed: 27832047]

Additional Online References

Choose Wisely: Avoiding Unnecessary Antibiotics in Ambulatory Practice: https://asp.nm.org/uploads/b/90789983-155283105139956222/181105.2_choose_wisely_antibiotics_for_delivery_610.mp4.