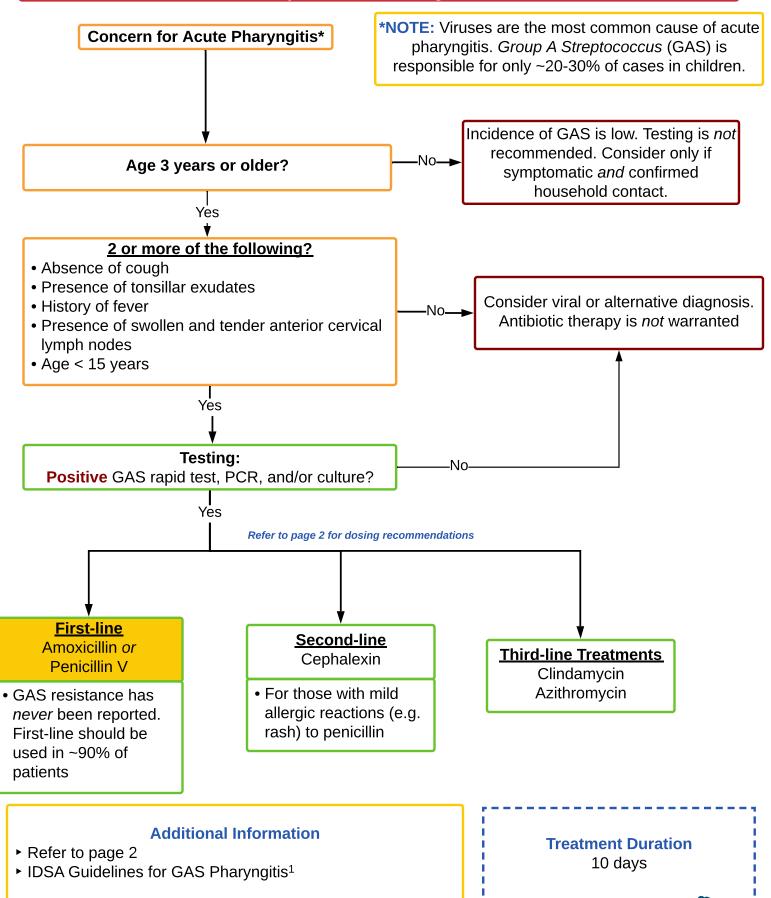
# Pediatric Uncomplicated Acute Pharyngitis Empiric Treatment Algorithm



## **Pediatric Acute Pharyngitis Clinical Pearls**

### **Testing and Treatment Considerations**

- ► Follow-up testing after antibiotic treatment is not recommended. Positive results are usually indicative of a streptococcal carrier and further antibiotic treatment is not warranted
- Over-testing and treatment of acute pharyngitis in adults and children lead to an estimated 7 million courses of unnecessary antibiotics per year<sup>2</sup>
- ▶ **Cefdinir** is *not* recommended as an alternate treatment for children in IDSA GAS guidelines¹ and is not preferred for treatment of pediatric upper respiratory infections due to (1) poor pharmacokinetic (PK) characteristics; (2) high rates of resistance; and (3) broad but mismatched spectrum of coverage³,4,5
- Up to 90% of penicillin allergies are misdiagnosed. Always clarify history of allergy and de-label if appropriate (e.g. family history without patient history). For a full allergy assessment and testing, consider referral to outpatient allergy.

### **Pharyngitis Antibiotic Dosing**

- ► Amoxicillin 50 mg/kg oral once daily (max 1000 mg) or 25 mg/kg BID (max 500 mg)
- ► Penicillin V, oral
  - ► Children: 250 mg BID or TID; adolescents and adults: 250 mg QID or 500 mg BID
- ▶ Benzathine penicillin G, IM
  - ► <27 kg: 600,000 U; >/=27 kg: 1,200,000 U
- ► Cephalexin 20 mg/kg oral BID (max 500 mg/dose)
- ► Clindamycin 7 mg/kg oral TID (max 300 mg/dose)
- ► Azithromycin 12 mg/kg oral once daily (max 500 mg)

#### References

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This work was supported, in part, by the Kentucky Cabinet for Health and Family Services Department for Medicaid Services under a State University Partnership contract; Norton Children's Hospital; and the University of Louisville School of Medicine, Department of Pediatrics.

