# PRIMARY CARE MANAGEMENT GUIDELINES

## Tonsillitis

**DATE & VERSION:** 26 August 2004, 12:22.05  
**NATIONAL GUIDELINE**  
**DISTRICT HEALTH BOARD:** National

**Tonsillitis** is usually an acute infective condition. The common causative organisms are viruses, *Streptococcus pneumoniae* (S. pneumoniae), Beta-haemolytic streptococcus (ß-haemolytic strep) and *Haemophilus influenzae* (H. influenzae). Chronic tonsillar infection can present with recurrent throat pain and / or tonsillar debris with halitosis.

### CLINICAL PROBLEM

**Clinical Determinants**

### ACTIONS

### LOCAL IMPLEMENTATION REQUIREMENTS

#### ACUTE TONSILLITIS

<table>
<thead>
<tr>
<th>Acute tonsillitis – initial presentation</th>
<th>Analgesia</th>
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</table>
| Acute tonsillitis and risk of rheumatic fever | Analgesia  
Culture or empirical treatment | Specify local treatment preferences and likelihood of rheumatic fever |
| Acute tonsillitis not responding to treatment after 48 hours | Throat swab to establish viral or bacterial aetiology  
Full blood count (FBC)  
Monospot / Infectious mononucleosis (IM) serology | GP management  
[Discuss local reliance of throat swabs for treatment or treat empirically] |
| Acute bacterial tonsillitis | Phenoxymethylpenicillin² 25-50 mg/kg/day up to 500 mg twice daily for 7 days (10 days if risk of rheumatic fever) |
| Acute tonsillitis, unable to swallow and dehydrated | Consult Specialist urgently | [Local referral mechanism for urgent referral] |

#### INFECTIOUS MONONUCLEOSIS (IM)

| Suspected infectious mononucleosis | IM serology  
Analgesia  
Consider treating associated tonsillitis with an antibiotic if diagnosis uncertain. AVOID AMOXICILLIN |
| Complicated by difficulty in swallowing and breathing | Consult Specialist urgently | [Local referral mechanism for urgent admission] |

#### RECURRENT TONSILLITIS

| All patients | Four-week course of phenoxymethylpenicillin² |
| Patients not responding to a four-week course of phenoxymethylpenicillin | Consult Specialist⁴ |
| Recurrent tonsillitis with symptoms of Sleep Breathing Disorder⁵ in children | Consult Specialist |

#### TONSILLITIS WITH PERITONSILLAR CELLULITIS / QUINSY

| Early in history and able to swallow | Phenoxymethylpenicillin² 25-50 mg/kg/day up to 500 mg twice daily for 7 days (10 days if risk of rheumatic fever)  
Review at 12 and 24 hours | GP management  
[IM or IV if compliance is an issue] |
| Cannot swallow | Consult Specialist urgently | [Local referral mechanism for urgent referral] |

#### CHRONIC TONSILLITIS

| Chronic tonsillitis | Consult Specialist | Proforma referral |

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**SEE NOTES ON REVERSE >>>**
Tonsillitis

NOTES:

1. **Acute Tonsillitis**: throat pain, painful swallowing and either of tonsillar enlargement or cervical lymphadenopathy.
2. If allergic to penicillin use a macrolide e.g. erythromycin.
3. **Recurrent Tonsillitis**: seven or more episodes of tonsillitis in the preceding 12 months, 5 per year in the preceding 2 years or 3 per year in the preceding 3 years.
4. National ORL referral criteria – Category 4 (routine within 26 weeks).
5. Snoring, choking, night waking, enuresis, ill tempered on waking, day time somnolence.
6. **Chronic Tonsillitis**: persistent infection of the tonsil associated with repeated sore throat localised to the tonsils, with or without tonsillar debris.

REFERRAL LETTER INFORMATION:

- Demographics
- Specific critical determinants leading to referral

REFERENCES

Statement of Clinical Effectiveness. BAOL (British Association of Otorhinolaryngologists) website.

ADDITIONAL INFORMATION

The Elective Services Respiratory National Referral Guidelines & Clinical Priority Assessment Criteria and the Tonsillitis Primary Care Management Guidelines can be found at: www.electiveservices.govt.nz

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This management guideline has been prepared to provide general guidance with respect to a specific clinical condition. It should be used only as an aid for clinical decision making and in conjunction with other information available. The material has been assembled by a group of primary care practitioners and specialists in the field. Where evidence based information is available, it has been utilised by the group. In the absence of evidence based information, the guideline consists of a consensus view of current, generally accepted clinical practice.

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