PRIMARY CARE MANAGEMENT GUIDELINES
Tonsillitis

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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[1]		
Acute tonsillitis – initial presentation	Analgesia	
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	Phenoxymethylpenicillin[2] 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 AMOXYCILLIN	GP management
Complicated by difficulty in swallowing and breathing	Consult Specialist urgently	[Local referral mechanism for urgent admission]
RECURRENT TONSILLITIS [3]		
All patients	Four-week course of phenoxymethylpenicillin[2]	
Patients not responding to a four-week course of phenoxymethylpenicillin	Consult Specialist[4]	Proforma referral
Recurrent tonsillitis with symptoms of Sleep Breathing Disorder[5] in children	Consult Specialist	Proforma referral
TONSILLITIS WITH PERITONSILLAR CELLULITIS / QUINSY		
Early in history and able to swallow	• Phenoxymethylpenicillin[2] 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 [6]		
Chronic tonsillitis	Consult Specialist	Proforma referral

SEE NOTES ON REVERSE >>>

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