Dear pharmacist

CPCS - Managing referrals for sore throat and ear conditions

We have been receiving increasing reports from community pharmacies of inappropriate referrals sent via GPCPCS, where the patient requires antibiotics for sore throat and ear conditions. Conversely, we are equally receiving reports from GP practices where patients are being inappropriately escalated back for a GP appointment following a referral to community pharmacy for these conditions. When reviewed by the GP, many of these patients have not required antibiotics and could have effectively been managed within the community.

Whether patients are assessed by the GP or the Community Pharmacist it is important that the current national NICE guidelines are followed and reviewing the NICE Clinical Knowledge Summaries is required when providing the GPCPCS service.

I am working with the GP practices and front-line teams to ensure they are trained in identifying red flags to reduce the volume of inappropriate referrals that community pharmacies are receiving.

To address this situation from both sides, and effectively improve the service, it would be beneficial for you to assess your own current level of knowledge and confidence in managing patients with these conditions and consider whether this is an area for continuing professional development for your revalidation.

To support you in managing patients with sore throats and acute otitis media, please find attached some key points that I have pulled out from the national guidelines. I have also included links to the NICE CKS and tools that are available to support you in your decisions for managing these patients.

I am aware that the GPCPCS does not provide remuneration to community pharmacies to perform ear examinations under this service, and some pharmacists will not be trained or have equipment to carry out this procedure. Whilst I have provided the guideline summary for acute otitis media, it is important that in the absence of this examination, you consider all differential diagnoses when presented with patients with ear conditions. I have included in the references, links to the Clinical Knowledge Summaries for otitis externa and earwax.

If you require any further support with regards to the GPCPCS service, please do not hesitate to contact me or your PCN lead.

Kind regards
Karen

Acute sore throat

References:
https://cks.nice.org.uk/topics/sore-throat-acute/ January 2021
https://cks.nice.org.uk/topics/sore-throat-acute/diagnosis/diagnosing-the-cause/ January 2021
https://www.mdcalc.com/calc/3316/feverpain-score-strep-pharyngitis

- The term 'sore throat' describes the symptoms of pain at the back of the mouth. Clinical descriptions of acute sore throat include:
  - Acute pharyngitis: inflammation of the part of the throat behind the soft palate (oropharynx).
  - Tonsilitis: inflammation of the tonsils.

- **Sore throat due to a viral or bacterial cause is a self-limiting condition. Symptoms resolve within 3 days in 40% of people, and within 1 week in 85% of people, irrespective of whether or not the sore throat is due to a streptococcal infection.**

- Management of a person presenting with a sore throat involves:
  - Admitting the person immediately if they have stridor, breathing difficulty, clinical dehydration, or a condition that is immediately life-threatening such as acute epiglottis or Kawasaki disease.
  - Referring people with a suspected serious but not immediately life-threatening cause for sore throat (such as cancer or HIV).
  - Giving simple advice, if appropriate, for example, regular use of paracetamol or ibuprofen to relieve pain and fever, and adequate fluid intake to avoid dehydration until the discomfort and swelling subside.
  - Prescribing antibiotic treatment, if appropriate. FeverPAIN and Centor clinical prediction scores should be used to assist the decision on whether to prescribe an antibiotic.
  - Arranging specialist assessment for people with recurrent tonsillitis (a frequency of more than 7 episodes per year for one year, 5 per year for 2 years, or 3 per year for 3 years) as they may benefit from tonsillectomy.

- **For acute sore throat of any cause being managed in primary care, advise the person that:**
  - **Adequate fluid should be taken during the course of the illness.**
  - **Ibuprofen and paracetamol can be used as an antipyretic and/or analgesic.** For detailed prescribing information on paracetamol and ibuprofen, see the CKS topics on analgesia - mild-to-moderate pain, NSAIDs - prescribing issues, and Feverish children - risk assessment.
  - **Saltwater gargling, medicated lozenges (containing a local anaesthetic and NSAID or an antiseptic agent) may provide temporary relief from throat pain.**
  - **Hot drinks should be avoided as these can exacerbate pain.**
  - **Children may return to school or daycare after fever has resolved and they are no longer feeling unwell, and/or after taking antibiotics for at least 24 hours.**

- Routine follow-up is not required, however, the person should be advised to seek follow-up if:
  - Symptoms have not improved after 3 or 4 days of antibiotic therapy — so that alternative diagnoses can be considered.
  - Pain does not improve after 3 days, and/or there is fever over 38.3°C — so that antibiotic treatment can be initiated (if not in place already) or alternative diagnoses can be considered.
  - It becomes difficult to swallow saliva or liquids, if any difficulty in breathing develops, or if there is any one-sided neck or throat swelling — so that the need for hospital admission can be reassessed (the person should be advised to seek advice urgently in these scenarios).

FeverPAIN and Centor scoring tools

Consider the person's signs and symptoms, and use the FeverPAIN or Centor clinical prediction score to determine the likelihood of streptococcal infection (and therefore the need for antibiotic treatment):

- Acute Group A streptococcal (GAS) pharyngitis/tonsillitis is common in children and adolescents aged 5 to 15 years and is more common in the winter (or early spring) in temperate climates. Streptococcal infection is suggested by fever > 38.5°C, exudate on the pharynx/tonsils, anterior neck lymphadenopathy, and absence of cough. A scarlatiniform rash may be present, especially in children.

- The **FeverPAIN** criteria are: score 1 point for each (maximum score of 5)
  - **Fever** over 38°C.
  - **P**urulence (pharyngeal/tonsillar exudate).
  - **A**ttend rapidly (3 days or less)
  - Severely **I**nflamed tonsils
  - **N**o cough or coryza

A score of 0 or 1 is associated with a 13% to 18% likelihood of isolating streptococcus.
A score of 2 or 3 is associated with a 34% to 40% likelihood of isolating streptococcus.
A score of 4 or 5 is associated with a 62% to 65% likelihood of isolating streptococcus.

- The **Centor** criteria are: score 1 point for each (maximum score of 4)
  - Tonsillar exudate
  - Tender anterior cervical lymphadenopathy or lymphadenitis
  - History of fever (over 38°C)
  - Absence of cough

A score of 0, 1 or 2 is thought to be associated with a 3 to 17% likelihood of isolating streptococcus. A score of 3 or 4 is thought to be associated with a 32 to 56% likelihood of isolating streptococcus.

Ear conditions

References:
https://cks.nice.org.uk/topics/otitis-media-acute/ March 2022
https://cks.nice.org.uk/topics/otitis-externa/ February 2022
https://cks.nice.org.uk/topics/earwax/ March 2021

Acute otitis media

- Acute otitis media (AOM) is defined as the presence of inflammation in the middle ear, associated with an effusion, and accompanied by the rapid onset of symptoms and signs of an ear infection.
- It is a common condition that can be caused by both viruses and bacteria.
- AOM occurs frequently in children but is less common in adults.
  - It most commonly affects children from birth to 4 years of age, especially those who are subject to passive smoking, attend daycare or nursery, are formula-fed, or have craniofacial abnormalities (such as cleft palate).
- Complications of AOM include recurrence of infection, hearing loss, tympanic membrane perforation, and rarely, mastoiditis, meningitis, intracranial abscess, sinus thrombosis, and facial nerve paralysis.
- In older children and adults, AOM usually presents with earache. Younger children may hold or rub their ear, or may have non-specific symptoms such as fever, crying, poor feeding, restlessness, cough, or rhinorrhoea.
- On examination the tympanic membrane is distinctly red, yellow, or cloudy and may be bulging.
- **Pain and fever should be managed with paracetamol or ibuprofen.**
- **Many people with AOM will not need antibiotic treatment as symptoms usually resolve spontaneously within a few days. However, antibiotics are necessary in a number of situations, including for:**
  - **People who are systemically very unwell.**
  - **People who have symptoms and signs of a more serious illness or condition.**
  - **People who have a high risk of complications.**
- If an antibiotic is required, a 5–7 day course of amoxicillin is recommended first-line. Clarithromycin or erythromycin are alternatives for people who are allergic to penicillin (erythromycin is preferred in pregnant women).
- The following groups of people should be admitted to hospital for immediate specialist assessment:
  - People with a severe systemic infection.
  - People with suspected complications of AOM, such as meningitis, mastoiditis, intracranial abscess, sinus thrombosis, or facial nerve paralysis.
  - Children younger than 3 months of age with a temperature of 38°C or more.
- Management of persistent AOM involves:
  - Reassessing the person.
  - Considering the need for paediatric or ENT referral or admission, depending on the clinical situation.
  - Considering a first-line antibiotic (if not already prescribed) or a second-line antibiotic if the initial treatment was ineffective.
- Measures to prevent recurrent AOM include:

- In children — avoiding exposure to passive smoking, use of dummies, and flat, supine feeding; and ensuring that children have had a complete course of pneumococcal vaccinations as part of the routine childhood immunization schedule.
- In adults — avoiding smoking and/or passive smoking.