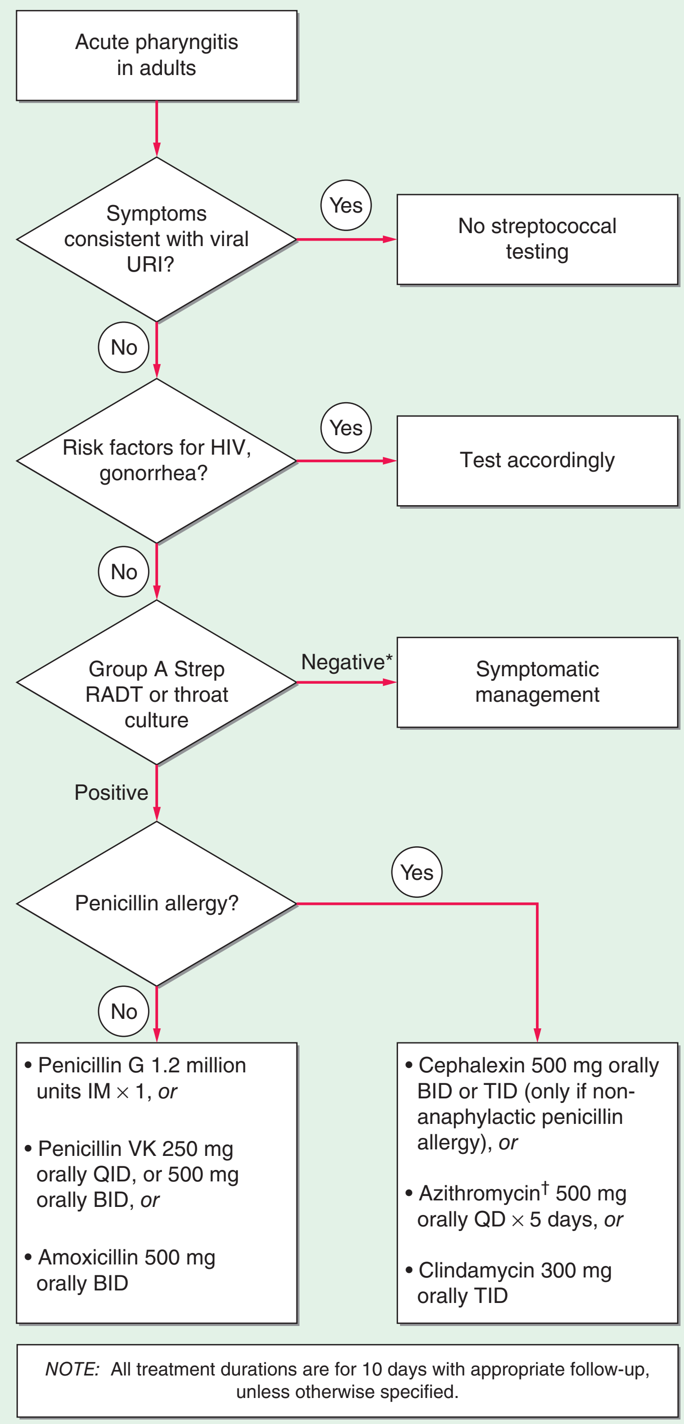
A hyperemic pharyngeal membrane with tonsillar hypertrophy and exudate is usually seen, along with tender anterior cervical adenopathy. Coryzal manifestations, including cough, are typically absent; when present, they suggest a viral etiology. Strains of *S. pyogenes* that generate erythrogenic toxin can also produce scarlet fever characterized by an erythematous rash and strawberry tongue. The other types of acute bacterial pharyngitis (e.g., gonococcal, diphtherial, and yersinial) often present as exudative pharyngitis with or without other clinical features. Their etiologies are often suggested only by the clinical history.

Diagnosis The primary goal of diagnostic testing is to separate acute streptococcal pharyngitis from pharyngitis of other etiologies (particularly viral) so that antibiotics can be prescribed more efficiently for patients in whom they may be beneficial. The most appropriate standard for the diagnosis of streptococcal pharyngitis, however, has not been established definitively. Throat swab culture is generally regarded as the most appropriate but cannot distinguish between infection and colonization and requires 24–48 h to yield results that vary with technique and culture conditions. Rapid antigen-detection tests offer good specificity (>90%) but lower sensitivity when implemented in routine practice. The sensitivity has also been shown to vary across the clinical spectrum of disease (65–90%). Several clinical prediction systems (Fig. 44-2) can increase the sensitivity of rapid antigen-detection tests to >90% in controlled settings. Since the



*Confirmation of a negative rapid antigen-detection test by a throat culture is not required in adults.
†Macrolides do not treat *F. necrophorum*, a cause of pharyngitis in young adults (see text).
Abbreviations: URI, upper respiratory infection; RADT, rapid antigen detection test

FIGURE 44-2 Algorithm for the diagnosis and treatment of acute pharyngitis.