

Group A streptococcus in children – guidance for primary and community care settings

Summary

16 December 2022, version 2

Updates from version 1 highlighted in yellow

To be read in conjunction with UKHSA/NHS England joint guideline.

Notifications of Group A streptococcal infections, including scarlet fever, invasive infections (iGAS) and severe pulmonary infections are higher than normal in England and causing significant public concern. Clinicians who may manage these patients should consider the following clinical guidance.

Clinical presentation

- Clinical presentation with Group A streptococcal infections is very variable, from mild to severe, and a high index of suspicion is essential.
- Skin, soft tissue and respiratory tract infections from GAS may result in tonsillitis, pharyngitis, scarlet fever, impetigo, erysipelas, cellulitis, and pneumonia.

Sore throat and non-severe symptoms

- **Throat swabs** for sore throat and non-severe symptoms are not required for all, but may be considered where there is diagnostic uncertainty, or concerns regarding antibiotic resistance.
- Rapid antigen tests for Strep A are not currently recommended to guide antibiotic prescribing and future recommendations should be based on high quality research.

Evaluations are being developed. Testing should be reserved for people being admitted to hospital or where a result is going to change management.

- Given the current higher prevalence of GAS, and the increased likelihood of GAS as a cause of sore throat in children, a lower threshold for prescription of antibiotics to children presenting with features of GAS infection should be considered, including when the presentation may be secondary to viral respiratory illness.
- A decision to treat tonsillitis with antibiotics in children can be guided by a **feverPAIN score** of 3 or more (this is a lower threshold in light of increased invasive Group A Strep incidence), in combination with clinical judgement.
- Due to problems with antibiotic supply a **Serious Shortage Protocol (SSP)** has been introduced by the Department of Health and Social Care. This protocol will allow pharmacists to supply a different formulation **or alternative antibiotic** in the event of non-availability of the phenoxymethylpenicillin. Clinicians do not need to change any practice. They can prescribe phenoxymethylpenicillin without considering the need for an alternative option.
- A tiered approach to alternative antibiotics has been sent to pharmacists. This means that families and patients will receive an appropriate antibiotic from their pharmacist.
- **Therefore, when a clinical decision has been made to treat a child with antibiotics please prescribe:**

SORE THROAT: a 5-day course of phenoxymethylpenicillin

SCARLET FEVER: a 10-day course of phenoxymethylpenicillin

- **For children with penicillin allergy, prescribe:**

SORE THROAT: a 5-day course of clarithromycin

SCARLET FEVER: a 10-day course of clarithromycin

- Guidance is available on encouraging children to swallow tablets/capsules available here: [How to give different types of medicines – Medicines For Children](#) Where not possible, the following is advice on crushing tablets: [Using solid oral dosage form antibiotics in children – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice](#)

- Safety netting as usual practice is required. Clinicians should have a low threshold for prompt referral to secondary care of any children presenting with persistent or worsening symptoms.

Invasive GAS

- Invasive GAS is rare and results in signs of severe sepsis. The following link highlights identification of risk of severe illness:

[Sepsis: recognition, diagnosis and early management \[NG51\]](#)

- Invasive GAS requires urgent referral and management in secondary care. Immediate treatment with IV antibiotics, even before transfer, should be considered.
- Rapid notification to Health Protection Teams of all cases of severe GAS infection is essential.

Prophylaxis Please refer to updated guidance for contacts of cases who are recommended for antibiotic prophylaxis due to higher risk of severe outcomes.