

UPPER RESPIRATORY TRACT INFECTIONS (URTIs)

Overuse of outpatient antibiotics has contributed to the emergence and spread of penicillin-resistant pneumococci. Most URIs are caused by viral pathogens and only rarely require antibiotics¹. Inappropriate antibiotics increase the risk of allergic reactions (urticaria, rash, anaphylaxis), adverse reactions (gastrointestinal, yeast infections) and drug-drug interactions.

Management of URIs in *immunocompetent* adults

	Usual pathogen	Diagnosis	Treatment	Comments
Nonspecific URI (Common cold)	Rhinovirus Adenovirus RSV Consider influenza or parainfluenza if prominent systemic symptoms	Naso-pharyngeal swab (NPS)	Symptomatic relief	Purulent nasal or pharyngeal discharge common with uncomplicated viral infection Consider empiric oseltamivir (Tamiflu) if high risk for influenza
Acute sinusitis (Sx < 4 weeks)	> 98% viral If bacterial: <i>Streptococcus pneumoniae</i> <i>Haemophilus influenzae</i>	Routine Xray or CT not helpful	Symptomatic relief	Reserve antibiotics if symptoms last ≥ 10 d , facial pain > 3 d, fever of ≥ 39 plus purulent discharge
Acute pharyngitis	Usually viral Group A strep (10%) Consider gonococcus, EBV, acute HIV	Rapid strep Request culture if rapid test is negative but high index of suspicion	If Group A Strep: penicillin (if true anaphylactic reaction to penicillin, consider macrolide or clindamycin)	Centor Criteria: tonsillar exudates, tender lymph nodes, absence of cough, fever. If all present, testing for GAS is indicated
Acute bronchitis (Cough ≤ 3 wks)	Usually viral 5%-10% 2° to pertussis, mycoplasma or chlamydia	Routine sputum gram stain or culture not helpful	Symptomatic relief Consider treatment for pertussis if high chance of exposure (eg epidemic)	Consider pneumonia if: HR ≥ 100, RR ≥ 24 , T ≥ 38°C OR focal lung exam