

been well described. The incubation period is 1–4 days. Symptoms include sore throat, fever and chills, malaise, and sometimes abdominal complaints and vomiting, particularly in children. Both symptoms and signs are quite variable, ranging from mild throat discomfort with minimal physical findings to high fever and severe sore throat associated with intense erythema and swelling of the pharyngeal mucosa and the presence of purulent exudate over the posterior pharyngeal wall and tonsillar pillars. Enlarged, tender anterior cervical lymph nodes commonly accompany exudative pharyngitis.

The differential diagnosis of streptococcal pharyngitis includes the many other bacterial and viral etiologies ([Table 148-2](#)). Streptococcal infection is an unlikely cause when symptoms and signs suggestive of viral infection are prominent (conjunctivitis, coryza, cough, hoarseness, or discrete ulcerative lesions of the buccal or pharyngeal mucosa). Because of the range of clinical presentations of streptococcal pharyngitis and the large number of other agents that can produce the same clinical picture, diagnosis of streptococcal pharyngitis on clinical grounds alone is not reliable. The throat culture remains the diagnostic gold standard. Culture of a throat specimen that is properly collected (i.e., by vigorous rubbing of a sterile swab over both tonsillar pillars) and properly processed is the most sensitive and specific means of definitive diagnosis. A rapid diagnostic test for latex agglutination or enzyme immunoassay of swab specimens is a useful adjunct to throat culture. While precise figures on sensitivity and specificity vary, rapid diagnostic tests generally are >95% specific. Thus, a positive result can be relied upon for definitive diagnosis and eliminates the need for throat culture. In settings in which the incidence of rheumatic fever is low, a confirmatory throat culture is not recommended for routine evaluation of most adults with a negative rapid test. However, because rapid diagnostic tests are less sensitive than throat culture (relative sensitivity in comparative studies, 70–90%), a negative result should be confirmed by throat culture for individuals at higher risk such as those with a history of rheumatic fever or immunocompromise or a family member with such a history; patients living in congregate settings of young adults such as dormitories or