Re: Role of Non-Group A Streptococci in Acute Pharyngitis

To the Editor: Jeffrey Tiemstra and Rosita L. F. Miranda[1] have added important data concerning the diagnosis and management of acute pharyngitis. Like previous investigators, they found that a significant percentage of adolescents and young adults presenting with acute pharyngitis grow streptococci from a group other than group A strep, which is the classic concern.

Most other articles on this subject have focused on group C and group G streptococci. I doubt that clinical presentation of group B resembles the clinical presentation of group C. In unpublished data, we did not find group B patients having such a presentation. Zwart also found that only A, C, and G caused pharyngitis.[2] Therefore, I would suggest that the authors look carefully at the distribution of clinical indicators in group B compared with group A and group C.

The Tiemstra article also shows that in practice (rather than in prospective studies) the sensitivity of the group A strep rapid test was only 75%. One can postulate several reasons for a difference in rapid test sensitivity from prospective studies. Just to suggest 2 possibilities: (1) sampling errors might occur more often in practice or (2) there may be publication bias for higher sensitivity studies.[3]

Like Zwart's classic 2000 BMJ study on treatment, the authors find a high probability of either group A or non-group A strep in patients having high pharyngitis scores.[3] That article supports a clinical improvement from antibiotics for group C strep pharyngitis. In that article adults (ages 15–60) experienced a 2-day symptom improvement if they had group A pharyngitis and a 1-day symptom improvement if they had group C pharyngitis.

The addition of headache to the pharyngitis scores, although understandable, makes comparison of this study to previous studies more difficult.

A note of caution: these findings probably apply to the adolescent/young adult age group and not pre-adolescents. Previous studies have shown that non-group A infections occur commonly in college health populations but not pre-adolescents.

Congratulations for continuing the documentation that adolescent and adult pharyngitis is more complex than deciding whether the patient has group A strep.

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References

1. Tiemstra J, Miranda RLF. Role of non-group A streptococci in acute pharyngitis. J Am Board Fam Med 2009;22:663–9.
2. Zwart S, Ruijs GJ, Sachs AP, van Leeuwen WJ, Gubbels JW, de Melker RA. Beta-haemolytic streptococci isolated from acute sore-throat patients: cause or coincidence? A case-control study in general practice. Scand J Infect Dis 2000;32:377–84.
3. Zwart S, Sachs AP, Ruijs GJ, Gubbels JW, Hoes AW, de Melker RA. Penicillin for acute sore throat: randomised double blind trial of seven days versus three days treatment or placebo in adults. BMJ 2000;320:150–4.

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The above letter was referred to the author of the article in question, who offers the following reply.

Response: Re: Role of Non-Group A Streptococci in Acute Pharyngitis

To the Editor: We appreciate Dr. Centor's[1] observations and comments on the literature regarding the role of non-group A strep in acute pharyngitis. In our population, group B was associated with 3 of the 4 classic criteria—fever, cervical adenopathy, and exudates—but not absence of cough (Figure 5 in our article[2]), suggesting that it may also represent a pathogen. Given the concerns for group B strep infection in the young adult population that includes pregnant women this certainly warrants further investigation, which we hope to pursue.

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References

1. Centor RM. Re: role of non-group A streptococci in acute pharyngitis. J Am Board Fam Med 2010;23:423.
2. Tiemstra J, Miranda RLF. Role of non-group A streptococci in acute pharyngitis. J Am Board Fam Med 2009;22:663–9.

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Re: Does Having a Personal Physician Improve Quality of Care in Diabetes?

To the Editor: We have read with interest the article by Hueston,[1] "Does having a personal physician improve quality of care in diabetes?" in your January/February issue, but we have serious reservations about his conclusion for several reasons.

First, although he cites 4 articles coauthored by Arch Mainous, he omits the one by Mainous most directly relevant to this article, which was Mainous and Gill (1998),[2] showing that for patients the benefits of continuity of care flow more from a personal relationship than from seeing others at the same site of care.